

BRUNNER/MAZEL PSYCHOSOCIAL STRESS SERIES

**POST-TRAUMATIC  
THERAPY  
— AND —  
VICTIMS  
OF VIOLENCE**

EDITED BY  
**FRANK M. OCHBERG, M.D.**















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## *Post-Traumatic Therapy and Victims of Violence*

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BRUNNER/MAZEL PSYCHOSOCIAL STRESS SERIES NO. 11

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*Post-Traumatic Therapy  
and Victims of Violence*

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*Edited by*

FRANK M. OCHBERG, M.D.



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## *Foreword*

This is an unusual and valuable book. The editor, Frank M. Ochberg, M.D., has been a pioneer in the study of victims of violence. As his understanding has deepened over the years, he has turned his attention to the treatment of such victims. In a highly compassionate way, he has brought to bear the knowledge and skills of several different professions in the effort to heal the wounds of those who have been suddenly and cruelly violated. This leadership has had a stimulating effect on workers in various fields who have come to recognize that the treatment of these victims is an important and neglected problem, one that has been tragically growing in the contemporary world.

In this volume, experts come together to pool their knowledge and experience so that others, too, will pay attention to victims of violence and their treatment will improve in the years to come. From several perspectives, the authors clarify what it means to be a victim of violence, what symptoms ensue, what people try to do to cope, and how others may help the victim to strengthen coping skills and work through the legacy of this extraordinary experience.

Frank Ochberg is a physician and psychiatrist who has taken the trouble over two decades to inform himself firsthand of the many facets of human aggression and violence. He has done excellent, scholarly work on these topics, being drawn from the beginning to an approach that would combine the insights of different disciplines. He worked at the interface between criminal justice and mental health. He learned about terrorism, including terrorist manipulation of the media, hostage negotiations, and victim behavior under extreme stress. He dealt with the victims of an unpopular war, with the victims of street crime, with the victims of terrorists, with the victims of household assault. Increasingly, Ochberg came to focus on the experience of the victim, trying to figure out what could be done to ease the suffering and diminish the likelihood of long-term casualties. From an early point in his career, he was sensitive to the human capacity to cope with stressful experience.



He sought to understand different patterns of coping behavior in different circumstances, and in recent years especially to see how coping strategies might be enhanced in the victim's situation. The breadth and scope of his experience led him into contact with scholars and practitioners of different perspectives, all sharing a common concern for the victims of violence.

This rich experience is reflected in Ochberg's choice of authors for the present volume and the topics they cover. Many different kinds of violence are dealt with, including violent crime in domestic situations and manifestations of war and atrocity in international circumstances. Altogether, they constitute very severe, stressful experiences, largely unexpected and unpredictable, typically involving intense emotional distress, jeopardy to vital human relations, and often a fundamental challenge to the meaning of life.

In their approach to treatment of victims, these various professionals tend to focus on the strengths of the victim, despite the injury. Behind the painful events of the trauma, these therapists see basic human assets and capabilities. They treat the victims with genuine respect and dignity. They seek existing coping skills, help to build upon these in new ways, and avoid any implication of further depreciation for a victim who is already feeling devalued. Essentially, the model used by the authors centers on stress and coping and is integrative with respect to biological, psychological, and social factors. Empathy for the victim comes through on almost every page, along with an open-minded searching for effective responses.

In the course of psychotherapy, the authors take into account five critical aspects of the victim's experience: bereavement; victimization; autonomic arousal; death imagery; and negative intimacy. Each of these appears in other stressful experiences to some extent, but each has a special and distinctive significance in the experience of victims of violence. The therapists are keenly aware of the unfortunate, unfair, and usually inadvertent tendency of our society to blame the victim for some part of the tragedy. The victim has enough to cope with without an additional heavy burden.

The authors recognize that psychological disturbances precipitated by trauma also have a biological aspect. For example, there may be a head injury, the significance of which is initially overlooked. In any event, the hyperalertness likely to be induced by a highly stressful experience has many biological ramifications in which the emergency response mechanisms of the brain, the autonomic nervous system, and the



endocrine system are prominent. Such reactions do not readily go away after a severely disturbing experience. For example, sleep disturbance is one manifestation of a tendency to keep scanning the environment for recurrent danger. Episodes of intense anxiety are not unusual. Depression also occurs. Such manifestations of distress can seriously interfere with the victim's ability to acquire new coping skills and come to terms with the post-traumatic situation. Therefore, judicious use of medication to facilitate sleep or to alleviate symptoms of emotional distress may be quite helpful. These matters are considered here along with the emphasis on individual psychotherapy and the social support network of the victim.

Many illuminating examples of specific human predicaments, involving people from different backgrounds in different circumstances, are given throughout the book. Much ingenuity is apparent in responding specifically and sensitively to individual needs, including the personal meaning of the events. Through all this diversity there are some basic orientations. To every victim the therapist brings an orientation which says in effect: "I am sorry this happened. And I am glad you were not killed. It was not your fault." Indeed, a "survivor psalm" evolved which became a part of therapy's termination for each patient. It is worth quoting here because it captures in a vivid and poignant way the essence of the objectives these therapists have sought in their difficult work.

I have been victimized.

I was in a fight that was not a fair fight.

I did not ask for the fight. I lost.

There is no shame in losing such fights, only in winning.

I have reached the stage of survivor and am no longer a slave of victim status.

I look back with sadness rather than hate.

I look forward with hope rather than despair.

I may never forget, but I need not constantly remember.

*I was* a victim.

*I am* a survivor.

Overall, this book provides humane insight and practical guidance for anyone who cares deeply about victims of violence. It fills a distinct ecological niche in the professional literature on this serious problem and also opens illuminating windows on wider problems of growing



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significance in the contemporary world. Once read, this volume will not soon be forgotten.

*David A. Hamburg, M.D.*  
President  
Carnegie Corporation of New York



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## Editorial Note

The Editorial Board of the Psychosocial Stress Book Series is proud and delighted to add the eleventh volume to the Series, *Post-Traumatic Therapy and Victims of Violence*, edited by Frank M. Ochberg, M.D. The Series strives to develop and publish books that in some way make a significant contribution to the understanding and management of the psychosocial stress-reaction paradigm. In particular, Series books are designed to advance the work of clinicians, researchers, and other professionals involved in the varied aspects of human services. These professionals must help clients confront and find solutions to the challenges associated with psychosocial stress.

This book and every book proposed for the Series is subjected to an intensive review by the Editorial Board. As a "refereed" book series, this insures that only the most important contributions are published. Indeed, the quality and significance of the Series are a product of this nationally and internationally respected group of scholars who compose the Editorial Board. Like the readership, the Board represents the fields of general medicine, pediatrics, psychiatry, nursing, psychology, sociology, social work, family therapy, political science, and anthropology.

This book focuses on a wide variety of victims and treatment methods. The volume's editor is an internationally known psychiatrist, former chair of the American Psychiatric Association's Task Force on Terrorism, former Director of the Michigan Department of Mental Health, and currently Clinical Professor of Psychiatry and Adjunct Professor of Criminal Justice at Michigan State University. Ochberg's introduction provides a good description of his impressive background (what he calls his "personal education in the field of victim services") and enormous qualifications for producing this book.

It is therefore not surprising that he was able to attract so many internationally known scholar-clinicians to contribute to this unique volume. Indeed, 17 scholars, primarily psychiatrists, nurses, and psychologists, have contributed 16 chapters divided among four interrelated



sections. Ochberg's introduction provides an excellent overview of the field of traumatic stress, including victim studies, and proposes some extremely important conceptual tools. These tools not only guide the reader in appreciating the chapters that follow, they sensitize us all to victim work. For example, early in the chapter he notes that those who work with victims of crime should think of victim status in *psychological terms* and PTSD in *physiological terms*. He argues that, different from other victims, victims of violence suffer from, among other things, shame, self-blame, subjugation, morbid hatred, paradoxical gratitude, defilement, sexual inhibition, resignation, second injury/wound, and a so-called "socioeconomic status downward drift." Later, he defines not only post-traumatic therapy (PTT) but also those other closely related concepts that have existed for many years in the clinical literature, vis-à-vis PTT: bereavement, victimization, autonomic arousal, death imagery, and negative intimacy.

Books in the Series, such as this one, focus on the stress associated with a wide variety of psychosocial stressors. Collectively, the books and chapters in the Series have focused on the immediate and long-term psychosocial consequences of extraordinary stressors such as war, divorce, parenting, separation, racism, social isolation, acute illness, drug addiction, death, sudden unemployment, rape, natural disasters, incest, crime victimization, and many others.

We are especially pleased to welcome Dr. Ochberg's book into the Psychosocial Stress Series. It provides not only a solid, scientific contribution to the field, but also shows the needed direction for clinical work. Together with this most recent volume, these Series books form a new orientation for thinking about human behavior under extraordinary conditions. They provide an integrated set of source books for scholars and practitioners interested in how and why some individuals and social systems thrive under stressful situations, while others do not.

Charles R. Figley, Ph.D.  
Series Editor  
Purdue University  
West Lafayette, Indiana



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*Post-Traumatic Therapy  
and Victims of Violence*

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# *Post-Traumatic Therapy and Victims of Violence*

FRANK M. OCHBERG

This volume about therapy for victims of violence is addressed primarily to clinicians—practitioners of the healing arts. Clinicians are a varied lot with remarkable differences in background, beliefs, and methods. These differences occasionally harden into orthodox schools of thought, dictating specific approaches to clinical problems and excluding the theory and technique of competing schools. On the other hand, most, if not all, therapists share common concerns regarding symptom reduction, enhancement of coping skills, and restoration of capacity for both independence and interdependence. Whether the clinician is a generalist, seeing a cross-section of clients, or a specialist, focusing on a particular problem or age group, he or she wants to serve the cause of psychological competence. The generalist, who treats the young and the elderly, the individual and the family, the worried well and the seriously impaired, has a broad experience of the human condition and sooner or later encounters the impact of victimization. The specialist may focus on rape or incest or military casualty and may work in a setting that attracts the victimized, such as a shelter for battered women, a probate court, or a Veterans Administration clinic. Furthermore, the specialist may have a particular technique or interest that increases the likelihood of working with victims. Examples include family therapy for incest situations, hypnotherapy for trauma survivors, and crisis intervention for victims of sexual assault. We expect both generalists and specialists to read this book and have designed the content and format accordingly.



We anticipate a secondary audience of students, health personnel, administrators, criminal justice professionals, family members, survivors of violence, and interested lay people who want to know how clinicians are advised to think about healing the wounds of victims of human violation.

We urge our readers to understand at the outset that being a victim of crime, a victim of war, a survivor of human cruelty is not the equivalent of being mentally ill. Specialists in victim services understand this. But generalists who care about serving victims may not. Victims often avoid mental health practitioners in order to avoid what they correctly perceive as a high risk of revictimization in a field that inadvertently patronizes and stigmatizes its clientele. A victim, by definition, has been violated and belittled; he or she can ill afford a second injury. Of course, mentally ill people are subject to victimization and, owing to economic and social deprivation, are victimized at relatively high rates. But the impact of human cruelty is experienced with a recognizable pattern of personal and interpersonal disruption and does not confer "patienthood" per se.

The authors invited to contribute chapters to this volume share a conviction that victims in treatment must be understood as normal people who are, for a period of time, thrown dramatically off balance by abnormal events, who suffer and endure, who may question their sanity and their virtue, who have a predilection for self-blame, who are at risk for physical and emotional illness, who respond well to succor and support, who can be helped with expert care, and who can be harmed by ignorance under a mask of expertise.

These authors are credentialed experts in their fields, nationally and internationally recognized for their work. They represent the state of the art of clinical victimology, a field that is at a historic turning point, coalescing such divergent streams as military medicine, domestic violence intervention, and sexual assault counseling. Many of the authors of chapters have treated hundreds or thousands of victims. Some have published extensively; others have concentrated their efforts on treatment rather than education.

This is a varied group, including physicians, nurses, psychologists, social workers, a sociologist, and a lawyer-philosopher. The orientations include the biological, psychological, interpersonal, and political. Colleagues regard some contributors as traditional, others as *avant-garde*.

My own work has been shaped by several historic events and unusual experiences. The assassinations of Martin Luther King and Robert Kennedy occurred while I was a psychiatric resident at Stanford. Colleagues



and friends were moved to examine the causes of violence in our society, and together we wrote *Violence and the Struggle for Existence* (Daniels, Gilula, & Ochberg, 1970). In her foreword, Coretta Scott King noted, "It is ironic that men who sought to eliminate violence in human affairs should have died by violence, and this reason alone should stimulate serious study to lead to its ultimate elimination in civilized society" (p. xi). We have made little progress in reducing violence, but some in understanding its impact.

Employed by the National Institute of Mental Health, I paid particular attention to the interface between the fields of mental health and criminal justice during the next decade. In 1975 the U.S. Department of Justice commissioned an inquiry into disorders and terrorism, holding hearings across the country and recommending standards and goals for government agencies (National Advisory Committee, 1977). As the representative of NIMH on the Committee, I learned about terrorist manipulation of media, hostage negotiation, and victim behavior under extreme stress. Conrad V. Hassel represented the FBI on the Committee. He suggested that I focus on the victim of terrorism. With the encouragement of the FBI and the support of the U.S. Public Health Service, I spent a year in Europe learning about victims of political terrorism and training detective negotiators in nonviolent conflict resolution methods. While I was abroad, Moluccan dissidents captured a school and a train in Holland, holding 160 men, women, and children hostage. I was a participant-observer in the forward command post and a collaborator in the design of a psychiatric reception center for victim-survivors. These events were reported in a later book, *Victims of Terrorism* (Ochberg & Soskis, 1982).

If the Stanford experience and the book *Violence and the Struggle for Existence* taught me that human aggression is deeply ingrained, multiply determined, and unlikely to be channeled into totally constructive behavior, the counterterrorist studies and the book *Victims of Terrorism* taught me to respect the human capacity to withstand extreme stress. Every victim I have known has described some coping mechanism, some aspect of survival behavior, and has therefore contributed to a general theory of post-traumatic adjustment.

After the year in Europe, a decade ago, I returned to the NIMH and served as Associate Director for Crisis Management, promoting disaster response plans, consulting to the U.S. Secret Service on stress among agents, and training Air Force officers on contingency planning for terrorism and sabotage. But two other experiences were far more important in shaping my approach to victims and victimization.

The first was a three-year term on the Committee on Women of the



American Psychiatric Association. Here I learned the depth of sexism in our institutions—a sometimes subtle, sometimes blatant bias against women who seek equal opportunity. This bias occurs in families, schools, the workplace, and among professionals. Feminist leadership in psychiatry is a very recent occurrence, but it is powerful and persuasive. Judith Herman, for example, has proved that the theories of Freud, applied to girls who complain about sexually abusive fathers, are completely wrong. Her evidence is compelling and well substantiated (Herman, 1981). But until women's voices were heard and heeded, the male tendency to doubt and blame the female victim held sway. This struggle is far from over, but a profound change in viewpoint has occurred in this decade. The feminist philosophy clearly evident in this book is no accident; it derives from the influence of feminist professionals who are, in my judgment, fair and correct in their analysis of female victimization.

My second experience was an unsuccessful candidacy for the post of Medical Director of the Veterans Administration. I had been encouraged to seek the position by several colleagues and in so doing became familiar with the medical, emotional, and political status of Vietnam veterans within the VA system. These were victims: hurt, hurting, and powerless. National sentiment against the war was still misdirected against the warrior (Ewalt, 1981). There was no honor to ease reentry. The nature of the conflict in the jungle, the extreme alienation, the particular era in American history—all made this war and these combatants subject to victimization syndromes. Not every Vietnam veteran had post-traumatic stress disorder, but many endured the fear, shame, and haunting recollection that typifies those who have experienced cruelty and betrayal.

So my personal education in the field of victim services came in all of the sectors that are responsible for the emergence of victimology as a national theme this decade: the women's movement (focusing anew our attention on incest, rape, and domestic assault), the end of the Vietnam era (allowing us to distinguish the warrior from the war), and the advent of political terrorism (bringing victims to the center of the world stage and into households everywhere, inviting us to identify with their crises and their coping skills).

Since 1981 I have concentrated on treating victims of violence in residential and outpatient settings, designing and implementing a stress reduction model of care (Ochberg & Fojtik, 1984). Our program, the Dimondale Center, accommodates up to seven clients in a deliberately permissive hospital environment, with training in physical fitness, re-



laxation, nutrition, and assertiveness; discussions of identity, anxiety, depression, and victimology; individual, group, and family therapy. When I see outpatients, I encourage participation in fitness programs and education in relaxation techniques. The psychotherapy approach is the same in residential or office settings.

## THE POST-TRAUMATIC STRESS DISORDER

The post-traumatic stress disorder (PTSD) is a relatively recent term defined in DSM-III (APA, 1980) and redefined in DSM-III-R (APA, 1987) as follows:

- A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.
- B. The traumatic event is persistently reexperienced in at least one of the following ways:
  - (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
  - (2) recurrent distressing dreams of the event
  - (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
  - (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma
- C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
  - (1) efforts to avoid thoughts or feelings associated with the trauma
  - (2) efforts to avoid activities or situations that arouse recollections of the trauma



- (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
  - (4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
  - (5) feeling of detachment or estrangement from others
  - (6) restricted range of affect, e.g., unable to have loving feelings
  - (7) sense of a foreshortened future, e.g., child does not expect to have a career, marriage, or children, or a long life
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
- (1) difficulty falling or staying asleep
  - (2) irritability or outbursts of anger
  - (3) difficulty concentrating
  - (4) hypervigilance
  - (5) exaggerated startle response
  - (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)
- E. Duration of the disturbance (symptoms in B, C, and D) of at least one month. (pp. 250-251)

I believe that we who work with victims of crime should think of victim status in psychological terms and PTSD in physiological terms. The victim may well have the classic triad of PTSD: haunting, intrusive recollection; numbing or constricted feeling and focus; and a lowered threshold for anxious arousal. But the victim is more likely to suffer symptoms from the following list, a distinct subcategory of traumatic stress that may or may not reach the threshold for PTSD:

1. Shame: deep embarrassment, often characterized as humiliation or mortification.
2. Self-Blame: exaggerated feelings of responsibility for the traumatic event, with guilt and remorse, despite obvious evidence of innocence.
3. Subjugation: feeling belittled, dehumanized, lowered in dominance, powerless, as a direct result of the trauma.
4. Morbid Hatred: obsessions of vengeance and preoccupation with hurting or humiliating the perpetrator, with or without outbursts of anger or rage.



5. Paradoxical Gratitude: positive feelings toward the victimizer ranging from compassion to romantic love, including attachment but not necessarily identification. The feelings are usually experienced as ironic but profound gratitude for the gift of life from one who has demonstrated the will to kill. (Also known as pathological transference and "Stockholm syndrome.")
6. Defilement: feeling dirty, disgusted, disgusting, tainted, "like spoiled goods," and in extreme cases, rotten and evil.
7. Sexual Inhibition: loss of libido, reduced capacity for intimacy, more frequently associated with sexual assault.
8. Resignation: a state of broken will or despair, often associated with repetitive victimization or prolonged exploitation, with markedly diminished interest in past or future.
9. Second Injury or Second Wound: revictimization through participation in the criminal justice, health, mental health, and other systems.
10. Socioeconomic Status Downward Drift: reduction of opportunity or life-style, and increased risk of repeat criminal victimization due to psychological, social, and vocational impairment.

Eventually we will have a diagnosis of victim stress disorder based on clinical evidence and treatment paradigms. Until then, clinicians must apply the officially recognized diagnostic categories that best fit each individual victim. When victimization is severe, PTSD will usually be the appropriate diagnosis.

## POST-TRAUMATIC THERAPY: CLINICAL PARADIGMS

Who was it who said, "There are two kinds of people in the world: Those who divide people into two kinds, and everybody else"? At the risk of being pigeonholed, I suggest that there are two kinds of psychotherapies applied to those who seek help after a traumatic event. One focuses on the preexisting personality and suggests that symptoms have more to do with the weaknesses, limitations, and unresolved antebellum issues than with the forces of the catastrophe itself and its aftermath. A second clinical approach concentrates far more on the recent events, the coping skills and strengths of the victim, the realistic



available options, and the correctable misconceptions or self-defeating thoughts that interfere with rapid emotional healing. I prefer the second approach as a place to start, and I prefer related approaches that presuppose no preexisting psychopathology, unless a client clearly indicates that post-traumatic adjustment is not the issue but pre-traumatic problems perhaps brought to the fore in stressful circumstances, are the prevailing reasons for help. The advantages in what I will now call post-traumatic therapy (PTT) are its assumption of psychological health, its fundamental assertion that the victim is not to blame, its ability to facilitate a working relationship between victim and therapist through partnership and parity in respect and power.

To practice PTT a therapist must, indeed, respect the dignity and potential strength of the client. This is communicated throughout therapy. Exploration of prior weaknesses, fixation points, or failures is deferred or omitted entirely. Five paradigms may be used to account for symptoms, apparent post-traumatic maladjustment, and any related problems. Each of these paradigms assumes the preexistence of coping skills and a modicum of psychological health. Each of these paradigms explains an aspect of unpleasant emotion and unpleasant circumstance in the aftermath of trauma. Each of these paradigms explains to the therapist and to the client reasons for suffering and expectations for healing. The five are bereavement, victimization, autonomic arousal, death imagery, and negative intimacy.

*Bereavement* is a well-explained and well-understood process which serves as a model for understanding each of the paradigms. Bereavement is a normal and painful emotional state which follows the loss of a loved one. Grief and mourning are related terms describing, respectively, the emotional and behavioral components of bereavement. But we grieve for more than the loss of loved ones. We grieve for the loss of ourselves, the diminution of ourselves, the loss of hopes and dreams, and the loss of a sense of security. I suggest we limit the concept of bereavement and grief to that expressed in Eric Lindemann's (1944) classic "Symptomatology and Management of Acute Grief." Persons who survive severe trauma may have, in the process, lost significant others or lost significant parts of themselves. If so, they should be expected to grieve the loss. Facilitated grief work includes the expression of affect, the understanding of the meaning of the lost person or object, the elucidation of ambivalence in the relationship, and the eventual freedom to attach trust and love to new significant others and, in appropriate ways, to new replacement objects.



*Victimization* is a process described by Symonds (1980) and Ochberg (1986) which is related to, but distinctly different from, bereavement. The bereaved loses a significant other. The victim is deliberately, unjustly harmed or coerced by another human being. The bereaved feels loss. The victim feels like a loser. The bereaved feels sad. The victim feels humiliated. The bereaved may feel as though a part of himself or herself has been ripped away. The victim often feels diminished, pushed down in a hierarchy of dominance, exploited, and invaded. These terms describe the act of victimization as much as they describe the ensuing feelings of the victim. Just as bereavement conjures up a time course of suffering, beginning with the loss and ending with reequilibration, victimization should suggest a similar transient state of personal disequilibrium, beginning with unanticipated trauma and ending with survivor status or reequilibration. But since we have so little language to explain victimization and few culturally accepted rituals of support, it becomes the task of the therapist to normalize the process. The therapist can actually explain the similarities and differences of bereavement and victimization. The therapist can help the victim understand the expected symptoms, the time course of healing, and the reasons for experiencing shame and ostracism, while disagreeing with those who perpetuate shame and ostracism.

*Autonomic arousal* is a physiological response to danger that has been well described and documented by Selye (1976) as a component of the general adaptation syndrome. Almost all trauma survivors can describe manifestations of autonomic nervous system activation. This could occur on seeing the injury or death of a loved one, on hearing shocking news, on assimilating the reality of a permanent loss, or on undergoing any phase of victimization. Such arousal is often experienced as fear. When it is revoked without a clear stimulus, it is experienced as anxiety. The clinical approach to post-traumatic fear or anxiety is best conceptualized according to DSM-III nomenclature as generalized anxiety, panic, or phobia and treated accordingly. Clarifying the particular pattern of anxiety leads clinician and client beyond the broad, descriptive diagnosis of post-traumatic stress disorder for an important reason: Specific pharmacotherapies and desensitization therapies exist for these distinct forms of anxiety. A client should make an informed choice among treatment options. Furthermore, a therapist should distinguish between treating a conditioned anxiety response and the psychological and social situation that derives from being victimized or bereaved. For example, a mother is injured by a hit-and-run driver and her daughter



is killed in the same accident. She is bereaved, victimized, and aroused. These are distinguishable aspects of the same traumatic event. It is normal for her to feel the common affects of bereavement: sadness, pain, perhaps anger or blame. It is normal for her to feel victimized: enraged, impotent, betrayed by justice; perhaps humiliated, isolated, or afraid. It is normal for her to experience recurring physiological arousal: pounding heart, generalized anxiety, and even panic. A reluctance to drive, to travel that road, is understandable. Therapists do a service to themselves and their clients by clarifying each feeling as it arises and the reasons for the feelings according to each paradigm. Otherwise the whole emotional disturbance may be even greater than the sum of its component parts, and the mother, in this case, not only suffers but loses a sense of self in the confusing array of powerful negative affects and imperfect societal reactions.

*Death imagery* is a concept developed by Robert J. Lifton (1967) in his work with holocaust survivors and prisoner-of-war victims. I was struck forcibly by the words of a Pan American Airlines stewardess who called me for help after surviving a jumbo-jet collision in the Canary Islands. She walked off a runway among 400 dead bodies and several months later told me, "I know I'm going to die." It took me a while to realize that she was not talking about a sense of impending doom, but rather a clear vision of her own death in stark biological terms which would come whenever it would come. We all know the same facts, but we seem to be protected by a beneficent veil of denial which allows us to live without an intrusive vision of our death. This stewardess lost her veil of denial. I propose that a fourth paradigm, separate and distinct from bereavement, victimization, and autonomic arousal, be the vision of death and the ensuing death imagery. Such imagery contributes to powerful and continuing fear. The therapeutic task becomes a difficult and individualized search for appropriate ways to shore up effective defenses, to diminish the intensity of recollection, to tolerate the pain of memory without triggering uncontrollable fear. Trauma victims will seldom suffer from death imagery problems alone, and their ability to cope with intrusive recollection is diminished when they are mourning, feeling victimized, and experiencing aftershocks of arousal. Therefore, working through death imagery must be accompanied by progress with the other appropriate paradigms.

*Negative intimacy* is a term I have coined to include such situations as kidnap, rape, and assault. Personal space and even one's personal



being have been invaded. People experiencing this often describe such sensations and feelings as "I was turned inside out," "I was defiled," "I was disgusted." The feeling of disgust is different from feelings described above and may be a remnant of an atavistic instinct to avoid diseased meat. We are disgusted by entrails, filth, rot. The survivor of trauma may be disgusted by himself or what he has seen. Self-loathing is not uncommon among rape victims. But more common is the generalization of loathing to large classes of people who resemble the victimizer. For some women this becomes all men. Several hostages have described their greatest humiliation as being forced to defecate in front of their captors. This negative intimacy adds the odor of excrement to the memory of victimization. A therapeutic challenge arises when client and therapist recognize the component of post-traumatic stress which derives from negative intimacy and is characterized by feelings of disgust and degradation. When this significant aspect is confronted, examined, and discussed in detail, it frequently diminishes and becomes a relatively minor factor.

These five paradigms certainly do not comprise an exhaustive list. They do include a sufficient number of conceptual approaches to allow clinician and client to collaborate. The collaboration assumes no preexisting deficits. It facilitates mastery over personal disequilibrium along predictable lines in the aftermath of a human tragedy.

## THE VICTIM OF VIOLENCE

Recently three people who received help at the Dimondale Center met with me to discuss their progress and their problems two years after brief, intensive therapy. Maria, Priscilla, and Bill illustrate many of the issues that arise in working with the battered spouse, the adult survivor of childhood incest, and the victim of aggravated assault. All had been, in various ways, captured, belittled, made vulnerable, and subjected to grief, anxiety, death imagery, negative intimacy, and victim status. Cultural factors and occupational setting were critical for Maria; somatization and anorgasmia characterized Priscilla's ordeal; and loss of status continues to impair Bill's life adjustment.

The following vignettes are disguised slightly to protect privacy, but significant aspects of therapy are reported as they occurred.

Maria was referred for residential treatment from a local shelter for



battered women. She is an attractive woman in her midthirties with two small children. She is from a Mexican-American family, raised in Texas, with a fundamentalist religious background. I met her for the first time in March 1983. Her face was clearly bruised. Her jaw had been dislocated. Her eye was swollen shut. She spoke in a flat, soft voice. Her apprehension was evident, and her story was sadly typical. Her second husband, married to her for three years, was a co-worker on the assembly line at the General Motors plant. He was jealous, possessive, domineering, and abusive when drunk. He was a competent worker, a reasonable stepfather, and unlikely to impress anyone as emotionally unstable. Maria did not believe that he would pursue her and threaten her, but she nevertheless preferred to keep her location a secret. Maria and subsequent clients involved in domestic abuse helped me and the Center staff learn about local law and procedures to safeguard battered spouses. Maria could have hired a lawyer and petitioned the court for an order, restraining her husband from visiting her at the Center. Without a court order, we, her physicians and nurses, could require unauthorized visitors to leave and could have such requests enforced by police under trespassing statutes. But trespass violators are merely escorted off the premises and not charged with an offense. Spouses who violate a court order can be fined and jailed for contempt. To facilitate this protection, we introduced Maria and subsequent clients to lawyers who, on a pro bono basis, explained procedures and, in one case, filed papers. These lawyers were either members of the pro bono committee of the county bar association or friendly state ex-officials in private practice willing to volunteer for a worthy cause.

Maria didn't need much help from us in changing her external environment. She knew how far the union and the plant management would go in arranging separate work stations for her and her husband. She knew how much patience her sister and brother-in-law had (enough to supervise her children for three weeks, but not for four). And she managed to arrange dental care, a household move, and a legal separation on her own.

She did need a refuge. She did need respect and caring. She used a physical-fitness program to repair a sense of wholesomeness about her body. She gradually overcame shyness and shame in group therapy sessions and became outspoken, assertive, and lively by the end of the first week. Her interest in other clients helped her feel potent and worthy. In role-play, in conversation with others, and in therapy sessions she learned to emphasize a positive self-appraisal. This required that she continue to distance herself from the mythology of her childhood.



which included witchcraft, male superiority, and determinism. Maria had, fortunately, come a long way herself toward a world view that permitted personal freedom. But brutality makes children of us all, and it helps to have one's better judgment reinforced.

Maria had some emotional setbacks during her three-week stay. Her optimism and her vivacity grew so quickly that her sister resented "her three-week vacation from responsibility." Frequent passes for visits to her children interrupted the residential treatment program and the sister's schedule. These tensions were difficult for Maria. Her buoyancy turned to bitterness. But the denouement in treatment included a realistic appraisal of her abilities and her environment, particularly her human environment. She left in the spring of 1983 with a sense of herself as a survivor.

Two and one-half years later, with minimal social-work counseling at a local mental health center, her self-esteem remains high, she is in a different job at the same plant, she lives with her children, she is divorced, she has not been battered, and she dates men on her own terms. She has had moments of fear and loneliness. But she looks happy and sounds resolute.

Priscilla is a few years older than Maria, also a mother of two. When I met her in mid-1982 she impressed me as fastidious, proper, almost prissy. A colleague in gastroenterology referred her to me because she cried uncontrollably during a sigmoidoscopy and her chronic "irritable bowel" seemed to have a functional component. As I came to know her through once-a-week outpatient therapy, I learned of other dimensions of her history and personality, but it wasn't until six months later, after her abdominal complaints subsided and her stress in raising a rebellious preadolescent became tolerable, that she began to speak about her brother. He would sneak into her room when she was eight and he was 10, lie naked with her, fondle her, and, occasionally, threaten her. There was no penetration, but she was frightened, disgusted, and felt evil. When she tried to explain matters to her mother she was accused of lying. For 30 years Priscilla kept this chapter of her life secret. Eventually she told her husband, but not her children, and certainly no one else. After confiding in me, she mentioned for the first time that she had never experienced an orgasm and that she never expected she would.

The Dimondale Center program was a realistic option for Priscilla because she was recovering from a hysterectomy and needed time away from work and home. In the program she told her story to others, she



learned relaxation techniques, she read about incest and sexual abuse, and she began to realize that she had been a victim. After feeling like a victim (rather than a secretive, bad little girl), she began to feel angry. In the company of women who knew how to express anger in no uncertain terms, she vented her feelings. And then, tutored by a forthright female therapist, she learned to masturbate to orgasm for the first time in her life. This led to a sexual relationship with her husband that was orgasmic.

It is now three years later. Priscilla has experienced minimal gastrointestinal distress after almost a decade of chronic pain. She is a far more assertive, self-reliant woman. Her marriage has ended, however. She sees this as a brave step forward, finding her husband stifling and unsuited for a woman with a mind of her own. She says she is a survivor and she is willing to take risks.

Bill is 40. A dozen years ago he was assaulted by a sword-wielding assailant and left for dead with a skull fracture, brain exudate, amputated thumb, arm hacked to the bone, and near-fatal blood loss.

Bill had one of those near-death dissociative experiences which I have now heard, firsthand, half a dozen times. In his case he felt serene as he floated up, out of his body, toward the ceiling and the door, then consciously decided to reenter his mangled corpus and accept pain in order to continue life.

When Bill reexperiences his terrible trauma, he also reexperiences this detachment and feels protected, as if he is on the way to heaven. I now look for this coping mechanism in cases of assault and consider it an important defense. Death imagery is far more devastating for witnesses of brutality than it is for victims like Bill who have experienced the peace that replaces pain and terror. And Bill, who may be the person who suffered the gravest injuries of those I have treated, is relatively unaffected by intrusive recollection. Bill lost his status, his livelihood, his family, and his privacy, and this is his victim-burden. Bill was and is homosexual. Bill was a schoolteacher. He now works for minimum wage in a group home. His parents have moved away and shun him.

Bill learned about my work from a television news program and came to the program for a month. We considered hypnotherapy, but it really was unnecessary. His recall for events was excellent and his ability to withstand gory imagery was better than mine. Several staff members required supportive sessions after hearing Bill's account. He was sensitive



to this and used humor to soften the impact when he could. Bill made friends, moved to another city, got a new job, was very active in a struggling self-help group of program graduates, but then had several setbacks. His job came to an end, he needed to depend on others for transportation, he returned to a somewhat degrading relationship with a benefactor from his previous home, and his resentment and bitterness about all his losses clouded his horizons. He can still manage to be cheerful, but he has not reached a satisfactory point in life. He feels that his therapy experiences helped him feel normal and potentially useful, but he hoped for a better adjustment.

Maria, Priscilla, and Bill have this in common: they were victimized by men who overpowered or threatened them, they were caused to feel fear and shame, they were belittled and hurt. They used a particular model of residential post-traumatic therapy to overcome various aspects of disability and achieve higher levels of independence. Maria emerged from a male-dominated household and workplace to find an enhanced self-esteem and an effective interpersonal style. Priscilla liberated herself from a self-imposed history of shame by finally placing blame where it belongs. It was Priscilla who said, as she left therapy, "For the first time I am looking forward to the rest of my life." And Bill, despite the hardship of his multiple injuries and losses, shares with Maria and Priscilla a sense of overcoming shame and an increased appreciation of meaning in his life.

The three individuals have remarkable differences in preexisting personality, culture, family, and social network. These differences obviously shape the possible outcomes of therapy. But for a critical month in each life, Maria, Priscilla, and Bill defined herself and himself as a victim, in order to appreciate the inevitable emotional climate of victim status and then move on.

Upon terminating therapy, each agreed,

I have been victimized.

I was in a fight that was not a fair fight.

I did not ask for the fight. I lost.

There is no shame in losing such fights, only in winning.

I have reached the stage of survivor and am no longer a slave of victim status.

I look back with sadness rather than hate.

I look forward with hope rather than despair.



I may never forget, but I need not constantly remember.  
I *was* a victim.  
I *am* a survivor.

This "Survivor Psalm" is useful in residential and outpatient work with victims of violence. It gives the therapist and the client a goal that has more to do with self-regard than merely with symptom reduction.

### CONCLUSION

Any attempt to describe therapy for victims of violence in one volume will not do justice to all perspectives, issues, and expert opinions. For example, we have no chapter on the minority victim, the geriatric victim, or the victim of harassment in the workplace. Our plan is to raise enough issues and discuss enough approaches so that clinicians will be encouraged to read further, to share their own experiences with colleagues, and to learn from victims themselves. This is an emerging area in psychotherapy. We are on the threshold of an unprecedented increase in mental health services for victims. The Victims of Crime Act of 1984 (P.L. 98-473) and similar state laws have opened new avenues to finance mental health care for victims. This is the decade of the President's Task Force on Victims of Crime (1982), the National Organization for Victim Assistance (see Chapters 15 and 16), and grass-roots organizations of, by, and for victims. Major mental health organizations have sponsored studies of victimization, and the mental health community is responding to the recommendation of the President's Task Force on Victims of Crime that

1. The mental health community should develop and provide immediate and long-term psychological treatment programs for victims of crime and their families.
2. The mental health community should establish training programs that will enable practitioners to treat crime victims and their families.
3. The mental health community should study the immediate and long-term psychological effects of criminal victimization.
4. The mental health community should work with public agencies, victim compensation boards, and private insurers to make psychological treatment readily available to crime victims and their families.



5. The mental health community should establish and maintain direct liaison with other victim service agencies. (p. 105)

The clinician who attempts to ameliorate the suffering of victims of human violence will find a growing body of relevant literature, an increasingly sensitive group of colleagues, and a broadening base of support. This is a long-overdue and most welcome development.

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## *SECTION I*

# Principles of Post-Traumatic Therapy

The therapist who treats victims of violence has a long list of techniques from which to choose. These include medication, education, psychotherapy, and family intervention. We begin this section with a review of the biological responses to psychic trauma and the implications for pharmacotherapy for two reasons: First, the medical model takes precedence over nonmedical interventions when injury to the nervous system is a possible cause of the presenting symptoms. Dr. Roth clarifies this crucial point in his discussion of the immediate post-traumatic period. Second, medication is necessary in some circumstances to reduce and prevent symptoms that interfere with education, psychotherapy, and family support.

In the opening chapter, Bessel van der Kolk explains how trauma reduces the victim's tolerance for arousal, causing either overreaction or underreaction to stressful stimulation. He relates this to animal models of inescapable stress and to research on opiate receptors in the human brain. Dr. van der Kolk began his work in this field with Vietnam veterans in Boston. As his research proceeded, it became obvious to him and his colleagues at Harvard Medical School that almost all of their findings were applicable to other populations of victims. He noted in a recent letter,

I have a long-standing interest in the fact that the mind dwells in a body, and that the two can only be artificially separated—this has allowed for equally devoted interest in the effects of trauma on opioid secretion in the locus ceruleus, and in doing



group therapy to overcome the disruption of interpersonal connectedness that follows traumatization. We now have a Trauma Center where we treat the effects of trauma on physically and sexually abused children, on crime victims, and on rape and incest victims. An ongoing research interest is the role of trauma in the development of psychopathology, and the biological basis for the commonly seen compulsion to repeat the trauma.

Extending Dr. van der Kolk's thesis by focusing attention on specific aspects of pharmacotherapy is the purpose of the next chapter. Walton T. Roth, Professor of Psychiatry at Stanford and Chief of Psychiatric Consultation at the Palo Alto VA Hospital, also argues for a balanced understanding of the mind-body continuum. His approach is eclectic and pragmatic. He explains the role of medication in post-traumatic therapy, including the issues of informed consent, suicidal potential, cumulative side effects, and dosages for elderly victims. Dr. Roth is a scientist with training in both psychoanalysis and psychopharmacology. His recent research on the mechanisms of panic disorder contribute to a psychobiological understanding of the human anxiety response.

After two chapters by physicians who focus on biological aspects of treatment, we turn to complementary and supplementary concerns. The disruption of the victim's physiological state is experienced as a disruption of the self and the family. Mary Merwin and Bonnie Smith-Kurtz describe how victimization injures one's life pattern, one's sense of humor, sense of justice, and sense of integrity. Dr. Merwin, a psychologist, and Ms. Smith-Kurtz, a nurse, have extensive experience in assessing and rehabilitating the chronic mentally ill—a vulnerable, victimized population. Recently they have begun applying their concepts of health education to providers of services to victims as well as providers of services to the mentally disabled. These concepts include self-help, stress management, health maintenance, spiritual development, and use of laughter as a healing tool.

For some reason the term "wholistic health" has become tarred with negative associations. Some regard the idea as unscientific or as reflecting counterculture values. This is an unfortunate linguistic development, because we have no alternative phrase to denote the comprehensive approach that Dr. Merwin and Ms. Smith-Kurtz present. Post-traumatic therapy is a wholistic model, based on an appreciation of traumatic disequilibrium: the whole person is affected and the whole person must achieve a new state of health and harmony.

Charles R. Figley concludes this section on principles of post-traumatic



therapy with his chapter on family therapy. For the last 10 years Dr. Figley has focused efforts on the entire field of traumatic stress studies. Through careful examination of people exposed to various types of highly stressful events, he and his colleagues at Purdue have developed several important theoretical models and assessment instruments for both research and treatment purposes. In his chapter he provides his basic approach to treatment with families of victims of violence. In contrast to other clinical scholars, his approach emerges from the study of families who have coped well with their ordeals, as well as those who have not. In my experience, the presence or absence of a supportive family is the single most important factor affecting recovery after victimization. Over 90% of the people seeking residential treatment for traumatic stress came to the Dimondale Center from nonsupportive families, suggesting that a healthy family is the preferred milieu for recovery. But the healthiest human group will be stressed by sudden, cruel injury to one of its members. Dr. Figley's chapter helps the clinician understand how family members help each other, and how family therapists can facilitate effective coping.

This first section is generic, in that it applies treatment principles to all categories of victims: young and old, military and civilian, men and women. Subsequent chapters treat specific circumstances, such as sexual assault, incest, and parents of murdered children. Obviously, the nature of victimization varies profoundly in these differing circumstances. The reader must bear this fact in mind while digesting the general principles of treatment that apply to most aspects of victimization.







# 2

## *The Biological Response to Psychic Trauma*

BESSEL A. VAN DER KOLK

Psychiatric interest in the human response to overwhelming psychological trauma has waxed and waned over the past century. Both Janet (1889) and Freud (1920) were deeply interested in the lasting psychological damage resulting from uncontrollably terrifying events, particularly those occurring early in the life-cycle, and both attributed many features of adult psychopathology to early traumatic life events. After Freud concluded that hysterical symptoms were not due to actual childhood trauma, but to intrapsychic elaborations of childhood fantasies, the role of trauma was abandoned as a central focus of psychiatric investigations. The more recent shift in psychiatric focus to a biomedical model has emphasized the investigation of biological and hereditary determinants of mental illness, again at the exclusion of the role of actual life events as determinants of mental illness. Current biological approaches to mental illness tend to be founded in the assumption that biological aspects of psychological phenomena are necessarily genetically based. This assumption excludes the overwhelming evidence that the central nervous system exists in a constant interplay with the environment and continues to some degree to be shaped by it throughout life, particularly during the first decade of life, when biological and cognitive functions mature in concert with the social surrounding (van der Kolk, 1986).

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An expanded version of this chapter, under the title "The Drug Treatment of Post-Traumatic Stress Disorder," first appeared in the *Journal of Affective Disorders*, 1987, 13, 203-213. Reprinted with permission.



Over the years, a small literature has accumulated describing the human response to such overwhelming trauma as child abuse, incest, rape, wars, and concentration camp experiences. However, only in recent years have we come to realize that the response to trauma is relatively consistent across these life events. It appears that the central nervous system has a limited and rather consistent response to overwhelming life experiences. This chapter examines our still very limited knowledge about the nature of the biological changes to terrifying life events and introduces the psychopharmacological treatment of post-traumatic states, which is explored in more detail in Chapter 3.

Kardiner (1941) first described the full syndrome of what is now called post-traumatic stress disorder (PTSD). Forty years later, his descriptions were incorporated, with few changes, into the formal DSM-III diagnostic criteria for PTSD. Kardiner noted that sufferers from PTSD continue to live in the emotional environment of the traumatic event, with enduring vigilance for and sensitivity to environmental threat. He described the five principal features of PTSD as (1) persistence of startle response and irritability, (2) proclivity to explosive outbursts of aggression, (3) fixation on the trauma, (4) constriction of the general level of personality functioning, and (5) atypical dream life. One can divide the symptoms into positive and negative clusters: The positive symptoms are hyperreactivity, explosive aggressive outbursts, startle responses, and intrusive recollections; the negative symptoms are constriction, social isolation, retreat from family obligations, anhedonia, and a sense of estrangement. After a traumatic event most victims go through a period of phasic reliving (with positive symptoms) and denial (with negative symptoms) (Lindemann, 1942; Horowitz, 1976). In mild cases the trauma is eventually successfully resolved with an integration of the traumatic events into the totality of a person's life experiences. However, in many people the condition becomes chronic, with various degrees of residual post-traumatic symptomatology.

The post-traumatic symptoms of hyperalertness, hyperreactivity to stimuli, and traumatic reexperiencing have been documented not only in the vast literature on combat trauma, but also following crimes, such as rape (e.g., Burgess & Holstrom, 1974) and kidnapping (Terr, 1983), natural disasters (e.g., Erikson, 1976), accidents (e.g., Wilkinson, 1983), and imprisonment (Krystal, 1968). In recent years it has been found that a high proportion of psychiatric patients have a childhood history of severe physical and sexual abuse (Carmen, Rieker, & Mills, 1984; Herman, 1986; van der Kolk, 1986) and that many of these patients show syndromes reminiscent of the post-traumatic sequelae in adults,



such as physiological hyperreactivity, a subjective sense of loss of control, chronic passivity alternating with uncontrolled violence against the self or others, and sleep disturbances, including nightmares which are often undisguised re-creations of earlier traumatic events. These patients carry a variety of psychiatric diagnoses, and many of them are diagnosed as borderline or hysterical personalities (van der Kolk, 1986). In addition, many patients appear to use drugs and alcohol to reduce post-traumatic symptomatology (Lacoursiere, Godfrey, & Rubey, 1980).

### ETIOLOGICAL MODELS OF POST-TRAUMATIC STRESS DISORDER

Explanations of PTSD have been offered on both psychological and physiological levels. Freud (1920) and Pavlov (1927) have each proposed psychological models, whereas other observers, starting with Selye (1956) have viewed PTSD primarily as a physiological disturbance. Freud's view was that trauma led to increased libidinal excitation, which led to a break in the "stimulus barrier." He described a compulsion to repeat the trauma, which he saw as an attempt by the organism to drain this excess energy. By redoing and repeating the trauma (in dreams and awake) the individual transforms the passive, victim stance to the active, mastery stance.

Pavlov (1927) formulated the second psychological explanation of PTSD. He coined the term "defensive reaction" to denote the cluster of innate reflexive responses to environmental threat. After repeated aversive stimulation, cues associated with the trauma (conditioned stimuli) become capable of eliciting the defensive reaction by themselves (conditional response). For a Vietnam veteran the sound of a passing helicopter can call up the experience of combat as many as 15 years after the original association was forged.

Regardless of the explanation, traumatized people have a poor tolerance for arousal. They have a tendency to react to stress either with motoric discharge, including acts of aggression against the self or others, or with social and emotional withdrawal (Kolb, 1984). Rorschach tests of Vietnam veterans (van der Kolk & Ducey, 1984) with chronic PTSD show that they have difficulty in modulating affect: either they respond to emotional stimulation with an intensity appropriate to the original trauma, or they barely react at all. These test results indicate a resulting lack of capacity to symbolize, fantasize, or sublimate. Hence, these patients are deprived of exactly those psychological mechanisms which



allow people to cope with the small injuries of daily life and to accumulate restitutive, gratifying experiences.

The psychological treatment of traumatization has focused on abreaction of the trauma, a technique first elaborated by Lindemann (1942). Hypnosis and group psychotherapy have both been shown to promote abreaction and to help with the psychological integration of the trauma (Horowitz, 1976). However, for many patients unearthing the trauma becomes only a reliving, rather than a dispelling, of nightmares (Lidz, 1946), and many patients are unable to fully integrate past psychological traumas.

Although psychotherapy is the cornerstone of successful treatment of PTSD, it cannot proceed as long as the patient is unable to tolerate the feelings associated with the trauma and continues to experience subsequent emotionally stimulating events as an unmodified recurrence of the trauma. Therefore, it is sometimes necessary to supplement psychotherapy with medications that decrease the anxiety accompanying the recurrent intrusive reexperiencing of affective or cognitive elements of the trauma. Most medications proposed for the treatment of PTSD serve to control increased autonomic arousal.

#### PHYSIOLOGICAL SEQUELAE OF TRAUMATIZATION

Kardiner (1941) was struck by this continuing physiological hyper-reactivity, and he coined the term "physioneurosis" to describe post-traumatic stress. He pointed out that while people with PTSD tend to deal with their environment by emotional constriction, their bodies continue to react to certain physical and emotional stimuli as if there were a continuing threat of annihilation. The autonomic nervous system (ANS) of people with PTSD appears to continue to prepare them for action. Several studies (Dobbs & Wilson, 1960; Malloy, Fairbank, & Keane, 1983; Kolb & Multipassi, 1982) have demonstrated an increase in ANS activity in veterans upon reexposure to combat stimuli, where they reacted physically or affectively as they had in a previous combat setting. It is a matter of controversy whether this hyperarousal is a conditioned response to traumatic stimuli alone. The evidence favors the view that increased autonomic arousal is a nonspecific response that is independent of the specific nature of the stimulus. In fact, it seems that habituation occurs to the original traumatic stimuli, but that associated events are met with hyperreactivity (Strian & Klicpera, 1978).



Vietnam veterans may misinterpret the movements of a sleeping bed partner as a Viet Cong attack and react accordingly; mild noises played into the rooms of sleeping people with post-traumatic stress may precipitate nightmares in which old traumatic occurrences are recreated in exact detail (Kramer, Schoen, & Kinney, 1984). An illustration of how autonomic arousal is associated with flashback phenomena was provided by a former parachutist who had a three-month period of symptoms of PTSD after his second parachute failed to open until he was a few hundred feet above the ground. Five years later the only remaining symptom is a flashback of this event after autonomic arousal, such as occurs in a near car accident.

This increase in the intensity of autonomic arousal leads to an intensification of emotional reactions in general. Eysenck (1968) has proposed that, after only one exposure to an intensely anxiety-producing stimulus, further anxiety attacks may occur in a stronger form, even in the absence of the original stimulus (Napalkow phenomenon). The intensity of the autonomic arousal may interfere with the capacity to make an appropriate psychological assessment of the stimulus and thus lead to an emergency response to relatively minor stimuli. Many traumatized people seem to go immediately from stimulus to response without being able to make an intervening assessment of the cause of their arousal.

## THE ANIMAL MODEL OF INESCAPABLE SHOCK

Since the biological building blocks of human beings and our mammalian relatives are closely related, particularly in regard to such relatively uncomplicated reactions as fight, flight, and freeze reactions to external danger, important lessons can be drawn from our knowledge of animal reactions to life-threatening situations. The animal model of inescapable shock (IS) provides an opportunity to study the physiological response in PTSD and the biological substrate of its psychological effects. Exposure to inescapable aversive events has widespread behavioral and physiological effects in animals, including (1) deficits in learning to escape novel adverse situations, (2) decreased motivation for learning new contingencies, and (3) evidence of chronic subjective distress (Maier & Seligman, 1976). It has been established that the helplessness syndrome seen after exposure to inescapable shock is due to the lack of control that the animal has in terminating shock and that the behavioral and biochemical sequelae of escapable shock tend to be in the opposite



direction of those of inescapable shock (Weiss, Glazer, Pohorecky, et al., 1975).

Inescapable stress will result in norepinephrine (NE) and dopamine depletion (presumably due to the fact that utilization exceeds synthesis). However, when shock is escapable, NE levels are not lowered, and may even increase (Anisman, Ritch, & Sklar, 1981). Anisman and Sklar (1979) found that shocks with no measurable effects on naive animals produced NE depletion and escape deficits in mice previously exposed to IS. Thus, NE depletion may become a conditioned response, which then gives rise to NE receptor hypersensitivity (van der Kolk, Greenberg, Boyd, et al., 1985).

There is a striking parallel between the animal response to inescapable shock and the human response to overwhelming trauma: Grinker and Spiegel (1945) described a myriad of autonomic and extrapyramidal symptoms of catecholamine depletion, such as masked facies, reduced eyeblink, cogwheel rigidity, postural flexion, and coarse tremor of the extremities, following acute combat stress in World War II soldiers. The behavioral sequelae of catecholamine depletion following IS in animals closely parallel the negative symptoms of PTSD in humans. Van der Kolk et al. (1985) have proposed that the diminished motivation, decline in occupational functioning, and global constriction seen in PTSD are correlates of a relative NE depletion. The clinical symptomatology of hyperreactivity (with startle responses, explosive outbursts, nightmares, and intrusive recollections) coincides with the establishment of chronic noradrenergic hypersensitivity following transient catecholamine depletion after acute trauma in animals.

The locus ceruleus (LC) is the primary source of noradrenergic innervation of the limbic system, the cerebral cortex, the cerebellum, and to a lesser degree, the hypothalamus (Grant & Redmond, 1981). The LC also plays a role in memory retrieval facilitation by means of the noradrenergic tracts emanating from the LC to the hippocampus and amygdala (Delaney, Tussi, & Gold, 1983). On the basis of animal data van der Kolk et al. (1985) have hypothesized that a long-term augmentation of the LC pathways following trauma underlies the repetitive intrusive reliving of the trauma, particularly under conditions of stress. Since autonomic arousal is mediated by the LC, it is plausible that not only flashbacks, but also traumatic nightmares, occur following autonomic nervous system activation, mediated by the potentiated pathways from the LC to the hippocampus and amygdala. This could also account for the eidetic, rather than oneiric, quality of traumatic nightmares (van der Kolk, Blitz, Burr, et al., 1984).



The noradrenergic system is intimately involved in short-term memory: noradrenergic depletion results in a decrease in memory storage, while enhancement of noradrenergic activity with NE-stimulating agents causes increased memory retention (Gold & Zornetzer, 1983). Preliminary data from our laboratory indicate that there is a marked decrease in short-term memory for emotionally neutral stimuli in individuals during the constricted phase of PTSD, compared with the same subjects during states of relative hyperarousal.

### *PTSD and the Endogenous Opioid System*

Animals exposed to inescapable shock develop analgesia when reexposed to a subsequent stressor within a brief period of time. This analgesic response to prolonged or repeated stress is mediated by endogenous opioids and is readily reversible by naloxone (Kelly, 1982). Christie and Chesher (1982) have demonstrated that prolonged stress in animals activates brain opiate receptors in a manner analogous to repeated application of exogenous opiates. Both naloxone injections and termination of the stressful stimuli produced opiate withdrawal symptoms. These results indicate that severe, chronic stress may result in a physiological state resembling dependence on high levels of endogenous opioids.

In humans elevations of plasma beta endorphins have been reported following stress (Cohen, Pichas, Dubois, et al., 1982) and in marathon runners (Colt, Wardlaw, & Frantz, 1981). A recent study found raised met-enkephalins in some patients who habitually mutilate themselves (Coid, Allolio, & Rees, 1983). It is likely that reexposure to traumatic situations in humans evokes an endogenous opioid response analogous to that seen in animals in response to even mild shock subsequent to inescapable shock. Thus, reexposure to stress may have the same effect as temporary application of exogenous opioids. This may account for the sense of calm in the face of reexposure to stress reported by many traumatized individuals (for a detailed discussion, see van der Kolk, 1986).

The reciprocal relationship between the opioids and the noradrenergic system is well established. The LC appears to mediate the opioid withdrawal syndrome: e.g., LC stimulation produces the behavioral and psychological signs indicative of the opiate abstinence syndrome in opiate-naïve monkeys (Redmond & Krystal, 1984). There is a striking parallel between the symptoms of opiate withdrawal and the hyper-reactive symptoms of PTSD; Jaffe and Martin (1980) list the following



symptoms of opiate withdrawal: anxiety, irritability, explosive outbursts, insomnia, hyperalertness, and emotional lability. Parallel symptoms of PTSD, as listed in the DSM-III, are: hyperalertness, startle responses, difficulty falling asleep, anxiety, and unpredictable explosions of aggressive behavior.

It seems plausible that the physiological aspects of the seemingly unrelated syndromes of opiate withdrawal and PTSD may have a common etiology, namely, that both are, at least in part, due to central noradrenergic hyperactivity associated with a relative decrease in brain opioid receptor binding. The symptoms of opiate withdrawal are thought to be mediated by the noradrenergic system, and they have been effectively treated with clonidine, an alpha-2 adrenergic agonist (Redmond & Krystal, 1984). Recently, Kolb et al. (1984) have found clonidine to be useful in treating the hyperreactivity in PTSD as well. Thus, while an endogenous opioid release following reexposure to traumatic stimuli may result in a temporary sense of control, it may also lead to withdrawal symptoms manifested by sleep disturbances, hyperreactivity, and explosive outbursts of aggression, which lead to further erosion of psychophysiological control.

### THE PSYCHOPHARMACOLOGICAL TREATMENT OF POST-TRAUMATIC STRESS

Clinical reports have claimed success for every class of psychoactive medication for the treatment of certain features of PTSD, including benzodiazepines (van der Kolk, 1983), tricyclic antidepressants (Burstein, 1984), monamine oxidase inhibitors (Hogben & Cornfield, 1981; Levenson, Lanman, & Rankin, 1982; van der Kolk, 1983), lithium carbonate (van der Kolk, 1983), beta-adrenergic blockers (Kolb, Burris, & Griffiths, 1984), clonidine (Kolb, Burris, & Griffiths, 1984), carbamazepine, and antipsychotic agents. However, no carefully controlled studies documenting the differential effects of various psychotropic medications on the symptoms of PTSD exist at this time. The similarities between the psychopharmacological treatment approaches to the borderline syndrome and to PTSD are striking (Herman & van der Kolk, 1986). While the state of the art of the psychopharmacological treatment of borderline patients is scarcely more advanced than that of patients with PTSD, the suggestion of a close relationship between these conditions may allow the understanding of pharmacological treatments of one condition to be applied to the other.



The availability of the animal model of inescapable shock allows for opportunities to understand the biochemical and physiological correlates of traumatization and may provide clues to the drug treatment of PTSD. A variety of psychopharmacological agents—including clonidine, benzodiazepines, monoamine oxidase inhibitors, and tricyclic antidepressants—decrease the long-term effects of inescapable shock in animals (for a review, see van der Kolk, Boyd, Krystal, et al., 1984). Such a clear animal model is unique in psychiatric research, yet the extensive literature on the biochemical and physiological sequelae of inescapable shock in animals has not yet been applied to post-traumatic stress in humans.

The animal model of inescapable shock and clinical studies of war veterans have shown that the autonomic nervous system is centrally involved in many of the symptoms of PTSD, including startle reactions, irritability, nightmares and flashbacks, and explosive outbursts of aggression. It is therefore predictable that those medications which affect autonomic arousal would prove helpful in treating the symptoms of PTSD. Autonomic arousal can be reduced at different levels in the central nervous system: through inhibition of noradrenergic activity (clonidine and the beta-adrenergic blockers), by increasing the inhibitory effect of the GABAergic system with GABAergic agonists (the benzodiazepines), and through stabilization of the central nervous system (CNS) with miscellaneous agents, such as lithium and carbamazepine. Although positive results have been claimed for all these medications, at the present time there are no data about which patient, or even what symptom of PTSD, will predictably respond to any of these medications.

#### *Medications that Affect the Noradrenergic System*

Clonidine is known to block alpha-2 receptors in the LC, which manufactures most of the CNS NE that travels through neuronal axons to the synaptic clefts. The beta blockers have a selective sympatholytic action on the peripheral nervous system (and a variable effect on the CNS) which leads to a reduction in the intensity of the somatic symptoms of anxiety. Kolb's patients who received either clonidine or propranolol (Kolb, Burris, & Griffiths, 1984) reported a decrease in startle responses, explosiveness, intrusive reexperiencing, and nightmares while on both propranolol and clonidine. Clonidine was prescribed in doses of .2-.4 mg/day and propranolol in doses of 120-180 mg/day. In our experience, up to 640 mg of propranolol has sometimes been needed to achieve a



satisfactory response in patients who have not responded to other forms of psychopharmacological intervention. However, patients run the risk of developing organic brain syndromes at these high doses.

### *Benzodiazepines*

In contrast to the beta-blocking drugs, the anxiolytic effect of the benzodiazepines is due not to blockade of the peripheral autonomic nervous system, but to their effect on the CNS GABAergic system. This system has a central inhibitory effect and thus influences the symptoms of autonomic arousal and anxious mood through action on the CNS (Tyrer & Lader, 1974). Benzodiazepines decrease new learning in animals and humans by blocking anxiety in response to aversive stimuli (Carlton, Siegel, & Murphree, 1981), and this effect on learning may occur in patients who are chronically maintained on these medications. The benzodiazepines also improve sleep, decrease nightmares, and may decrease self-medication with alcohol. Many traumatized patients prefer diazepam because of its rapid absorption and peak activity within 20 minutes after oral administration. However, this rapid subjective relief enhances the likelihood of abusive use of this medication in some patients. Lorazepam and oxazepam are benzodiazepines that have a slower onset of action and shorter half-lives and hence have less abuse potential than diazepam. A cross-tolerance between the benzodiazepines and alcohol has frequently been noted.

### *Lithium and Carbamazepine*

It has been suggested that lithium can exert control over the mechanisms that govern the regulation of affect (Sheard & Marini, 1976). In a study in our laboratory (van der Kolk, 1983) patients started lithium treatment after feeling out of control, constantly on the verge of exploding, and emotionally removed from their families. Many said they wished they had died in Vietnam. All had frequent nightmares and startle reactions. Of the 22 patients tried on lithium to date, 14 have reported gaining a subjective sense of control over their lives. In these patients lithium decreased the tendency to react to stress as if it were a recurrence of their original trauma. Autonomic hyperarousal seemed to have been markedly diminished, and all responders reported a marked decrease in alcohol intake. Four patients stopped their medications because of side effects, and four reported no response. None of the lithium responders had a personal or family history of bipolar or cyclothymic illness.



Carbamezapine has been used in some patients with PTSD with results clinically indistinguishable from those obtained with lithium. This is particularly interesting in light of recent data that carbamezapine may be as effective in the treatment of bipolar disorder as lithium (Ballenger & Post, 1980).

In our experience, only those lithium and carbamezapine responders who remained in regular individual or group psychotherapy continued to take lithium as prescribed. Many patients reported preferring the excitement associated with reliving the trauma to the dull realities of everyday life. In our experience this has been a consistent finding in many Vietnam veterans with PTSD. It is not confined to those who receive lithium, which is known to cause emotional constriction. This failure to continue with prescribed medication has also been reported by many patients whose nightmares had been effectively treated with amitriptyline or benzodiazepines.

### *Antidepressant Drugs*

Tricyclic antidepressants are widely used for the treatment of chronic PTSD, and they appear to be effective for many PTSD patients in the constricted phase of PTSD. However, at this time there has been only one uncontrolled case report on the use of these medications in PTSD (Burstein, 1984). Amitriptyline is reputed to be particularly effective in the treatment of chronic post-traumatic nightmares.

Monoamine oxidase inhibitors have received particular attention in the PTSD literature following a report by Hogben and Cornfield (1981) that five PTSD sufferers who had been chronically hospitalized and who had symptoms of panic reactions showed a marked improvement after phenelzine treatment. They claimed a decrease in nightmares, improvement in motivation, and increased availability of affect for psychotherapy. In our experience both phenelzine and tranylcypromine may be helpful in patients who are primarily constricted. On the other hand, a number of patients who had chronic outbursts of aggression or chronically high levels of anxiety experienced an increase in intrusive traumatic recollections and in the expression of aggression (van der Kolk, 1983).

### CONCLUSION

At present our ignorance about the human response to overwhelming trauma is great. Very little is known about the long-term sequelae of



childhood trauma, or its relationship to adult psychopathology. The apparent fixation on the trauma and voluntary reexposure, which have been recognized since the time of Charcot, remain unexplored and poorly understood. Information is lacking on predisposing hereditary and personality factors, documented efficacy of acute crisis intervention, and the process of integration and resolution of the trauma.

Nevertheless, a promising increase in attention to the clinical problems of traumatized and victimized individuals is occurring in this decade. Generic and specific approaches to treatment are discussed in subsequent chapters. The inevitable biological response to psychic trauma can be modified by pharmacological interventions. Although no controlled studies on the efficacy of these interventions have been reported, there is ample evidence that medication may make life more bearable for victims of violence, allowing them to put emotional distance between themselves and post-traumatic events. This distance is necessary for victimized individuals to resume normal functioning and to be able to see the trauma as a historical, rather than a contemporary, event.

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# 3

## *The Role of Medication in Post-Traumatic Therapy*

WALTON T. ROTH

### RATIONALES FOR DRUG TREATMENT

Using drugs for treating trauma-precipitated psychological disturbances can elicit conceptual conflict in prescribers and clients who are able to think in terms of either biological or psychological frames of reference. Generally, psychoactive drugs are prescribed for biological "diseases" like schizophrenia or affective disorder, whose emergence can be regarded as the rising above threshold of a chronic biological vulnerability. The disease process has a partially or fully autonomous or endogenous character, so its symptomatic manifestations are relatively independent of external events. Although "precipitating events" may be found, these events are often obscure and of uncertain importance, even after careful and extensive investigation, and are usually irrelevant in choosing a treatment regimen. The usual treatment, medication, is regarded as suppressing a sometimes latent and sometimes overt morbid process that is maladaptive and subjectively unpleasant. This biological point of view may be conveyed to patients to motivate them to take their pills regularly over months and years.

Post-traumatic psychological disorders, on the other hand, are comprised of symptoms that are closely tied in substance and in timing to

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a specific event or events, and which, therefore, lend themselves to psychological conceptualization. The elements of these syndromes tend to be viewed as psychologically appropriate attempts at coping rather than expressions of pathological vulnerability. All the symptoms listed in DSM-III as criteria for post-traumatic stress disorder can be considered in this way. Reexperiencing the trauma is an attempt at cognitive reworking and mastery, not an obsessive reaction. Numbness is protection against affect, not a sign of a biological depression. Hyper-alertness and sleep disturbance are indications of a need to continually scan the environment for danger, since in retrospect if that had been done, the traumatic event might have been prevented. Memory impairment or trouble concentrating is a useful temporary defense against remembering too much or thinking too much, not an indication of organic brain deterioration. Avoidance of activities that arouse recollection of the traumatic event is almost too rational to qualify as a phobia.

Thus, the prescription of drugs to sufferers of post-traumatic syndromes raises the same critical question that was raised when drug treatment of psychiatric disorders burgeoned in the 1950s: Is the treatment of a psychological disorder by biological means a short-sighted suppression of symptoms that robs the patient of the motivation and resources to solve his or her true underlying psychological problems? This led to debates about the nature of mental illness and the compatibility of drug treatment with psychotherapy. One solution to this controversy was to divide by diagnosis the appropriate scope of psychological and biological conceptualizations and treatments. Generally, neurosis fell in the psychological category, and psychosis in the biological. Post-traumatic stress would be classified as the former.

However, this old solution is unsatisfactory for many reasons. From a philosophical and empirical standpoint, the dichotomy between psychology and biology—mind and body—is untenable. Stress can be generated by the mind and body, can affect the mind and body, and can be treated psychologically and biologically (Roth, 1982). Recent research has revealed a biological dimension to panic anxiety (Klein, 1980; Sheehan, 1982a), a symptom whose psychological explanation had been the pride of psychoanalysis and the basis for intensive psychotherapy. Successes in treating panic attacks with drugs have for the first time generated enthusiasm for biological therapy of a disorder that was classified as neurotic.

A better solution, and the one that guides the recommendations given here, is derived from an integrated psychobiological viewpoint, the



premises of which are the following: First, trauma elicits a variety of cognitive and affective activities, varying from person to person, which can include cognitive coping strategies, unconscious defense mechanisms, depression, anxiety, and even hallucinations and delusions. All these activities have both psychological and biological aspects, have both meanings and neurophysiological substrates. Post-traumatic stress disorder in the DSM-III is a limited and somewhat arbitrary listing of some of these possibilities, emphasizing symptoms that are not prominent in other DSM-III diagnoses (West & Coburn, 1984). Second, all these activities or symptoms are potentially part of an adaptation process leading to a new healthy equilibrium, perhaps even better than the previous equilibrium. Psychotherapeutic and psychosocial interventions can hasten and guide this reequilibration. However, these activities and symptoms, by their intensity or persistence, can be maladaptive or develop a life of their own that brings new problems. Cognitive coping can become obsessive rumination; unconscious defenses; rigidly maintained blindspots; and mourning, suicidal depression. Anxiety can begin to interfere with thinking and acting, and morbid fantasies can turn into hallucinations and delusions and lead to behavior destructive to oneself or others. When symptoms reach these proportions, their immediate attenuation or suppression is called for, and the quickest and most practical way to do that may be drug treatment.

Thus, drug treatment is not only justified under certain circumstances for sequelae of stressful events in general, but can be an essential part of treatment, the omission of which could be construed as maltreatment. The indication for drugs is that either the nature, intensity, or duration of a symptom has exceeded what is helpful for the optimum long-term outcome, and that there is reason to believe that a specific drug will be helpful. When symptoms are so intense that they compromise working-through and adaptation rather than promoting them, drug therapy must be considered and discussed with the patient. As will become apparent in the discussion that follows, a principal consideration in determining how symptoms should be treated is the recentness of the trauma that precipitated them.

## PATIENT CONSENT

Of course, the decision to embark on a course of drug treatment or any other treatment can never be made solely on the technical merits of the alternatives, or on the basis of a unilateral decision by the



physician member of the treatment team. It is important that the victim, who in the treatment context has become a client and consumer of medical services, is not made to feel that he or she is again in an uncontrolled situation where his or her fate is being determined by outside forces. Medical advice is hardly ever so imperative that it has no discussable pros and cons or any possibility of being refused. Informed consent is not just a legal concept—it is a humane and efficient way of achieving optimum health care. The rare exception is when the patient is so mentally debilitated that he or she cannot participate in treatment decisions, having insufficient insight into the fact of the disability or comprehension of the treatments being offered. In such cases, the options of the treatment team depend on how acutely treatment is needed. Immediate treatment to preserve life is always permissible, but in the longer term, some kind of consent from relatives and from legal authorities is necessary. In the United States the details of the laws governing consent to treatment vary from state to state.

Occasionally, health professionals and cognitively competent and well-informed patients cannot agree on a course of treatment. In times of stress it can be particularly difficult for the people affected to weigh treatment alternatives and make reasonable decisions. Even the most sophisticated health care consumers may have strong biases or superstitions about how mental and physical health are best promoted. The two polarities of bias about drug treatment are epitomized by patients who always want medications and those who never want them. In the first case the physician may partially accede to the patients' demands by prescribing an innocuous medication as a placebo, and in the second, the physician can argue this point of view and then may have to accept its rejection. A growing public fear of man-made food additives and awareness of drug disasters, such as the thalidomide catastrophe, have made patients more skeptical of advice to take medication. This skepticism borders on paranoia in certain people who, for example, attribute their mental upsets to "food allergies" or who follow radical or unusual diets.

#### THE IMMEDIATE POST-TRAUMATIC PERIOD

It is exceedingly important to be aware of the possibility that psychiatric symptoms in the immediate or intermediate post-traumatic period could be related to lesions of the nervous system produced by the traumatic events. Occult skull fractures, subdural hematomas, and



other forms of tissue or vascular damage to the brain can produce all the psychological symptoms associated with trauma. When memory loss is severe or when there are focal neurological signs (for example, weakness or loss of sensation on one side of the body), it is more obvious that brain damage may have occurred, but often the memory loss or focal signs are more subtle and can be misinterpreted or missed. Other symptoms that suggest neurological damage are drowsiness and difficulty in being aroused, headache, visual disturbances, stiff neck, and seizures. Prematurely administering drugs before nervous system lesions have been ruled out can delay their detection by providing a spurious reason for the victim's lethargy or fluctuating vigilance. Physical examination is always indicated after physical trauma, and a careful neurological examination and brain imaging should be included when severe or persistent psychiatric symptoms follow a physical trauma. Even when the trauma has not been physical, information about preexisting medical problems and their treatment is essential for prudent prescription of psychoactive medications. Especially with older victims, drug treatment should only be undertaken in the context of comprehensive medical evaluation and treatment.

In the first minutes and hours after acute victimization, the victim's affect may be aroused into states of fear or rage or be numbed into depressed withdrawal. The victim's thoughts may be suicidal, homicidal, or simply fixated on the traumatic event. Motor activity may be increased, with restlessness or pacing, or may be diminished. It is at this point that the possibility of "sedation" comes up, either by medicinal drugs or outside a professional setting with the layman's universal remedy, alcohol. When I was a medical intern, it was customary for a physician informing a woman that her husband or child had died to offer a barbiturate to help with the immediate grief. Although this gesture was a symbol of condolence and helping, its wisdom is as questionable as the wisdom of sedating a trauma victim. The victim is mentally working on reorganizing what has happened and its implications and on shoring up his or her mental defenses. The emotions accompanying this may be inevitable and culturally prescribed. Sedative drugs like barbiturates or benzodiazepines may cloud consciousness, impair memory, and decrease ego control. They may add to the person's not being him or herself rather than relieving those feelings. Thus, it is best to wait to give medication until special indications for it are present.

The general indication for medication is the presence of reactions that are destructive to present or future coping. Severe emotional ex-



citement with agitated motor behavior may lead to accidental or deliberate self-injury. For older people or those with known cardiovascular disease the autonomic concomitants of intense emotion can precipitate coronary ischemia, arrhythmias, or cerebral hemorrhages. In these cases, a sedating medication like diazepam (for doses, see Table 1) can be useful, though in rare cases such medications can paradoxically release, rather than suppress, emotions. If that occurs, an antipsychotic medication such as haloperidol could be substituted. The acute emotions induced by being victimized are varieties of anger, anxiety or fear, and sadness. The feeling of sadness combined with helplessness and hopelessness is not an immediate indication for antidepressant therapy. Antidepressants are not useful right after the trauma since their benefits are not immediate, and it cannot be certain initially whether the sadness will be sustained and become associated with the bodily changes that would classify a person as depressed.

Another symptom that can work against coping is insomnia. Sleeping medication need not be prescribed routinely on the first night after a trauma, but if insomnia is severe on that night, benzodiazepine-type sleeping medication should be given for a few nights. Complaints of poor sleep include difficulty falling asleep, waking up in the middle of the night sometimes because of nightmares, early-morning waking, and not feeling rested upon awakening. Any sleeping difficulty not due to depression may be treated initially with a short-acting benzodiazepine such as triazolam. This drug will usually result in seven or eight hours of sleep, but if patients complain of waking during the night after taking triazolam, there is a temptation to prescribe a longer-acting benzodiazepine such as flurazepam. Unfortunately, this drug has an active metabolite with a 40-to-100-hour half-life, which accumulates with repeated doses. If early-morning waking is accompanied by other symptoms of depression, it is more likely to respond to antidepressants than to benzodiazepines. Not feeling rested in the morning may have various causes, only one of which is poor sleep at night.

The possibility of suicidal overdoses of any prescribed medication must be kept in mind, and the kind and quantity of medicine prescribed should not permit a fatal overdose. The tremendous advantage of benzodiazepines over other hypnotics is their extraordinary safety in overdoses. Daytime and nighttime benzodiazepines may reinforce each other's effects and produce sleepiness when it is not wanted. There are no consistent pharmacological or adequately proven anxiety versus sedation differences between benzodiazepines marketed and FDA-approved as hypnotics and those marketed and approved as anxiolytics.



TABLE 1  
Selected Drugs for Post-Traumatic Therapy

Generic Name	Representative Brand Name	Initial Oral Dose (mg)	Dose Range (mg/day)	Indication
<i>Benzodiazepines</i>				
Diazepam	Valium	5-20	10-40	Sustained anxiety (long-acting)
Oxazepam	Serax	15-60	30-120	Sustained anxiety (short-acting)
Alprazolam	Xanax	0.25-0.5	1-8	Panic attacks (short-acting)
Triazolam	Halcion	0.125-0.25	0.125-0.5	Insomnia (very short-acting)
Flurazepam	Dalmane	15-30	15-30	Insomnia (short- and long-acting metabolites)
<i>Tricyclic Antidepressants</i>				
Imipramine	Tofranil	25	75-300	Depression, panic attacks
Desipramine	Norpramine	25	75-300	Depression, (activating, few anticholinergic effects)
<i>Other Antidepressants</i>				
Trazodone	Desyrel	50	150-600	Depression (sedative, few cardiac or anticholinergic effects)
<i>Monoamine Oxidase Inhibitors</i> (require dietary restrictions)				
Phenelzine	Nardil	15	60-90	Panic attacks, depression
<i>Antipsychotics</i> (often together with anti-Parkinsonism drugs)				
Haloperidol	Haldol	2	4-100	Psychotic symptoms (less sedative)
Chlorpromazine	Thorazine	25	100-800	Psychotic symptoms (more sedative)

Thus, if a patient has been taking a short-acting daytime benzodiazepine for anxiety, it is simplest to take the same drug at bedtime for insomnia. The greatest problem with benzodiazepines used as hypnotics is rebound insomnia when an attempt is made to stop the drug after several days of use (Kales et al., 1983). Other problems are habituation of their effects and hangovers on the morning after use (Solomon et al., 1979).



Furthermore, the sleep that benzodiazepines induce and maintain has less rapid eye movement (REM) and stage 4 sleep than natural sleep, a possible rationale for using them to suppress nightmares that occur during REM sleep or sleepwalking that occurs during stage 4. In conclusion, hypnotics are best used intermittently and infrequently. Non-drug aids to better sleep should be relied on for longer-term treatment (Hauri & Sateia, 1985). In certain kinds of patients hypnotics should be avoided altogether: pregnant women, patients with histories of alcohol or drug abuse, chronic obstructive pulmonary disease, or sleep apnea (Guilleminault et al., 1973). The last condition is found in people who snore and is particularly significant in the presence of hypertension or cardiac arrhythmias.

Dissociative or somatic "conversion" reactions may occur shortly after a trauma. Dissociation is a trancelike state in which the sense of personal identity or voluntary control is suppressed. Losses of memory usually accompany dissociation, ranging from minor gaps in recall of the traumatic event to not knowing one's own name or personal history. Sometimes the old "I" is replaced by a new personality, coming either from within the person or from an outside source. Somatic conversion reactions include perceptual alterations—anesthesias and paresthesias—and motor alterations—paralyses or weaknesses. Less often hallucinations appear, usually visual, but sometimes auditory or in another sensory modality. Pharmacotherapy has been used in such syndromes to produce reexperiencing of the trauma and abreaction of feelings (West & Coburn, 1984). The patient is heavily sedated and then engaged in a psychotherapeutic dialogue. Direct suppression of dissociative or conversion symptoms with drugs is unlikely to be successful. However, if the patient exhibits agitation or anxiety in addition, a benzodiazepine might be indicated. Most important is appropriate psychotherapeutic and behavioral management.

Rarely, the psychotic symptoms of what DSM-III calls brief reactive psychosis appear within hours or days of a trauma or during the stress of a prolonged traumatic event. If a victim shows signs of psychotic thinking, antipsychotic medication such as haloperidol may be indicated, as well as hospitalization. Examples of psychotic thinking are loose associations (trains of thought jump in irrelevant or bizarre directions), paranoid ideas (unreal ideas of persecution or of self-importance), delusions (idiosyncratic, fixed, false ideas), and ideas of reference (thinking that irrelevant environmental events are relevant). Hallucinations may accompany psychotic thinking, most often voices talking about the person in the third person, or to him. Two strategies of drug admin-



istration have been advocated for treating acute psychosis: giving gradually increasing oral doses of antipsychotic drugs or starting with high intramuscular doses (Anderson & Kuehnle, 1981). The second method is probably best if the patient needs physical restraint to protect him from acting on dangerous ideas. In a young man, 5–10 mg of haloperidol might be given intramuscularly every hour until significant symptomatic improvement is observed. A drug to counteract the Parkinsonian-like side effects of haloperidol, such as oral benztropine (Cogentin), 1 mg, may be given prophylactically with the first haloperidol dose and continued at 1–2 mg twice a day. An alternative anti-Parkinsonian drug without anticholinergic side effects is amantadine (Symmetrel), given in doses of 100 mg twice a day.

Certain circumstances may tempt the physician to prescribe a placebo. If the patient demands drugs for less than compelling reasons, if a patient has a history of drug or alcohol abuse, or if the patient manifests symptoms that are possibly hysterical, treatment personnel may conclude that inactive drugs would be less harmful or better for distinguishing between "real" and "conversion" symptoms than active drugs. This temptation to use placebos should almost always be resisted because the treatment of drug-demanding trauma victims or any other patients with placebos is fraught with hidden problems. The ordering of saline injections by a physician may seem straightforward, but it can communicate to the nurse that the patient's complaints are not legitimate, and the nurse may assume that any relief caused by the placebo is proof of this. The nurse is being asked to deceive the patient, which creates a breakdown of rapport even if the patient does not discover the deception. If the patient does discover it, he may well feel degraded and foolish, especially if he was initially "taken in" by the placebo by reacting positively to it. Except in research studies, where the use of placebos is essential and patients are informed beforehand that they may receive them, completely inert placebos should be avoided. On the other hand, the prescription of openly labeled, biologically active, but relatively harmless substances, like vitamins, might give the patient the benefits of a placebo without its negative repercussions.

It is important to remember that traumatic events can change the customary life habits of the victim and lead to inadvertent withdrawal from alcohol or other addicting drugs. A steady drinker who has never suffered from alcohol withdrawal before can unexpectedly develop withdrawal symptoms after circumstances like hospitalization for traumatic injuries have led to sudden suspension of drinking. Restlessness, tremulousness, agitation, difficulty sleeping, an elevated temperature,



and signs of sympathetic activation such as sweating and a rapid pulse suggest withdrawal from alcohol or barbiturates. If these symptoms are not treated, the patient may develop a full-blown picture of delirium tremens with loss of immediate memory, visual or tactile hallucinations, and possibly seizures. These later symptoms peak 48 to 60 hours after withdrawal and carry a mortality rate of as high as 15% if they do not receive proper medical attention (Sellers & Kalant, 1976). Diazepam, given intravenously in severe cases, has become a mainstay of treatment of alcohol withdrawal syndromes. These patients are also often vitamin deficient, especially thiamine deficient, and should receive supplemental vitamins.

### THE INTERMEDIATE POST-TRAUMATIC PERIOD

Persistence of symptoms over a period of days or weeks or the development of symptoms after a latent period of days or weeks may be an indication for drug therapy. The choice of drugs is the same as for the psychiatric disorder that the manifestations of the post-traumatic state most resemble. In the immediate post-traumatic period, symptoms may not fit into any typical psychiatric syndrome or diagnosis, but as time passes, persisting symptoms tend to fit these diagnoses better, either classical psychiatric diagnoses or the relatively new diagnosis of post-traumatic stress disorder.

Anxiety severe enough to meet DSM-III criteria for anxiety disorder is a common sequela of trauma (Katon, 1984). When doctor and patient agree that medication is indicated, the specific drug should be chosen on the basis of the presence or absence of panic attacks and the extent of daytime sleepiness and of depression. If no panic attacks are present and depression is absent or slight, the long-acting benzodiazepines are drugs of choice. If panic attacks are present, one must choose between three drugs or drug types: alprazolam (Xanax), a tricyclic, or a monamine oxidase inhibitor. Alprazolam is a short-acting benzodiazepine that suppresses panic attacks as efficiently or almost as efficiently as the tricyclic imipramine (Tofranil) (Chouinard et al., 1982). Its advantages over imipramine is that it works more rapidly and does not have imipramine's annoying anticholinergic side effects. Its disadvantages are that it can result in daytime sleepiness, and that if it is suddenly discontinued, rebound anxiety can occur. Tricyclics such as imipramine take several weeks to work and produce dry mouth, constipation, and other side effects, but are less sedating. It is unclear whether the new



antidepressives without cholinergic side effects are as effective as imipramine in blocking panic attacks. Monamine oxidase inhibitors such as phenelzine (Nardil) lack anticholinergic side effects and are less sedative than alprazolam. Phenelzine, however, requires patients to follow a special diet and often produces orthostatic hypotension. It can be especially effective in patients who are depressed with panic attacks and who tend to sleep during the day. In general, it is wiser to begin treatment of patients with significant depression and panic attacks with drugs like imipramine or phenelzine, which are more antidepressant than alprazolam.

Patients whose symptoms are primarily those of depression—depressed mood, emotional numbing, insomnia (particularly early-morning awakening), and loss of appetite (eventually with weight loss)—are candidates for antidepressant drugs. The best drug responders have more than just a sad mood and feelings of hopelessness and helplessness; they have weight and sleep disturbances and slowing of their thinking and movements in addition to, or rarely instead of, the former symptoms. Many new antidepressant drugs with fewer autonomic and cardiotoxic side effects than the older compounds are available. The clinician can also choose between antidepressants that are activating (promoting wakefulness and activity) and those that are sedative. Activating antidepressants are often prescribed when psychomotor retardation is present, and sedative antidepressants when anxiety and agitation predominate.

Symptoms of depression should alert the clinician to the possibility of suicide. Although it seems paradoxical, a person whose life was originally threatened by outside forces can later become a threat to his or her own life. There are a number of possible reasons for this: victims may have been left with disabilities that prevent them from continuing in their social roles; they may have developed unpleasant physical or psychological symptoms that rob them of the joy of life; they may have lost loved ones in the traumatic event; women may feel defiled or guilty about being raped, and their intimate relationships may have been disturbed; finally, being a survivor of traumatic events may entail guilt if there were other less lucky victims, especially if the survivor improved his chances at the expense of others. Any communications of suicidal thoughts or intentions that the treatment team becomes aware of should lead to immediate assessment of the victim's suicide potential. If that potential is high or if the patient has made a suicide attempt, hospitalization is ordinarily required.

Patients who develop other syndromes in the intermediate post-traumatic period for which drugs are indicated should be treated ac-



cordingly—symptoms of brief reactive psychosis or schizophreniform psychosis with antipsychotics, manic symptoms with antipsychotics and lithium, alcohol withdrawal syndromes with benzodiazepines. Detailed information on the variety of antidepressant, antipsychotic, and other psychotherapeutic drugs that are available in the United States can be found in Hollister (1983).

How dosage is divided over the day depends on the drug. Psychoactive drugs are usually begun in divided doses, three or four times a day, but when a satisfactory dose is reached for antidepressants or antipsychotics, the entire daily dose can be divided into two parts or given in a single dose. It should be made clear to the patient whether a drug is to be taken "as needed" or regularly. Antidepressant and antipsychotic drugs should certainly be taken regularly, whereas anti-anxiety drugs are often prescribed to be taken only when the patient feels anxious. In the case of panic attacks, as-needed prescription of short-acting agents like alprazolam may be ineffective because the attacks come unexpectedly. To block panic attacks, alprazolam should be taken every four to six hours.

Elderly patients may react to psychotropic drugs differently than young patients (Thompson et al., 1983). The pharmacokinetics of drugs may change with age owing to a smaller ratio between body water and fat, decreased serum albumin, decreased hepatic enzyme activity, and reduced creatinine clearance by the kidney. Elderly patients are also more likely already to be taking medications that interact with the effects of metabolism of psychotropic drugs. As a rule of thumb, patients older than 65 should receive 30–50% smaller doses of psychotropic drugs. The elimination of benzodiazepines with longer half-lives (diazepam, chlordiazepoxide, flurazepam) is retarded more in the elderly than the elimination of those with shorter half-lives (oxazepam, lorazepam). The last two have the theoretical advantage that their elimination depends on conjugation, which is less affected by liver disease and age than is oxidation (Greenblatt et al., 1983). Excessive doses of benzodiazepines lead to decreases in mental efficiency, drowsiness, and symptoms reminiscent of alcohol intoxication. In the case of benzodiazepines used as hypnotics, excessive doses may be manifested as confusion or ataxia when the patient wakes up at night to go to the bathroom, or as a morning hangover.

Antidepressants have several side effects that can be especially troublesome in the elderly. Anticholinergic effects such as impaired visual accommodation, urinary retention, decreased sweating and hyperthermia, and confusion or delirium can be minimized by using drugs like



desipramine or trazadone. These antidepressants are also less likely to produce orthostatic hypotension or electrocardiographic changes, such as longer QRS duration and QTc time. Blood level measurement can be useful in finding therapeutic doses of imipramine quickly and safely (Task Force, 1985). Antipsychotic agents are more likely to produce Parkinsonian symptoms, hypotension, skin photosensitivity, and the very rare side effect agranulocytosis in the elderly. Lithium carbonate is cleared by the kidney more slowly in elderly patients and is therefore more likely to result in toxic symptoms such as tremors, indigestion, nausea, abdominal pain, frequent stools, and slurred speech, if serum levels are not monitored frequently enough. Serum levels are raised by factors that deplete body water, such as dietary sodium restriction, decreased water intake, or diuretics. Lithium-induced clinical hypothyroidism is also more likely to develop in older patients.

The symptoms that define post-traumatic stress disorder (PTSD) are sufficiently different from those of the traditional psychiatric disorders that there is no guarantee that drugs successful in treating the latter have a place in treating PTSD. Persistent startle response, irritability and a proclivity for violence, and flashbacks and reliving of the trauma seem like unrelated symptoms, although van der Kolk notes, in Chapter 2, that something similar occurs in opiate withdrawal. He infers biological underpinnings of PTSD that imply that particular drugs can be effective in its treatment. He reviews the pharmacological treatment of PTSD, including the possible roles of agents affecting the noradrenergic system (clonidine and propranolol), GABA blockers (benzodiazepines), and antimanic drugs (lithium, carbamazepine).

## TERMINATION OF MEDICATION

Reevaluations of the need for medication must take place periodically after an effective drug regimen has been established. If, for example, drugs were used to treat symptoms occurring immediately after a severely traumatic event, a decrease in dose should be considered after social and psychological functioning has returned to near normal for a few weeks. The reason not to continue drugs longer than absolutely necessary is the possibility of known or unknown long-term adverse effects. The most serious such effect of the drugs we have mentioned is tardive dyskinesia, which develops after administration of antipsychotics. The symptoms are writhing and jerky movements of the tongue and mouth, in severe cases extending to the extremities. The best way



to avoid this complication is to restrict the indication of antipsychotics to overt psychosis and to administer them for only a few days or weeks, a reasonable length of time for the reactive psychotic symptoms of trauma victims. When benzodiazepine sleeping medications are taken on more than a few consecutive nights, their discontinuation may result in a couple of nights of poor sleep. Patients should be advised of this and encouraged to withstand the temptation to keep taking them indefinitely. Medications should generally be tapered down over a week or two rather than stopped abruptly. This is especially true for the short-acting benzodiazepines, whose abrupt withdrawal can induce rebound anxiety or even seizures.

It is important to be aware that discontinuing medication is often an emotionally laden event for victims. It can be taken as a sign that the victim no longer needs to suffer from the psychic wounds sustained. For some victims, this sign is proof of wellness and brings relief, but for others, it is a frightening message that society no longer considers them to be as sick as they feel. The anger felt against authorities who failed to protect the victim can be turned toward the medical authorities who fail to take the victim's continuing suffering seriously. When litigation is involved, the victim and his lawyer may regard withdrawal of the medication as weakening their case before the judge and jury. Until the case is settled, it may be impossible, even for the most skillful clinician, to separate conscious or unconscious magnification of complaints from legitimate persistent symptoms.

#### CLINICAL VIGNETTE

The following case is presented not as an example of an optimally handled and strikingly successful case of the pharmacotherapy of a trauma victim, but rather as an illustration of the complexities of treating an individual patient.

A woman in her late twenties came to a psychiatric clinic seeking treatment for panic attacks that began a few days after she had been raped late at night on a deserted city street of a major American city eight months previously. When she was first seen, her attacks were occurring once or twice a day. She experienced episodes of severe anxiety, rapid pulse, chest pain, and numbness and tingling in her hands and feet that lasted for 20 minutes or so. During the attacks she often thought she was going to die. Her anxiety persisted at a lower,



but still uncomfortable, level for hours after the attacks. They were not associated with specific stimuli and were not limited to any one location. They could occur in her apartment, although they were more likely outside it. She lived with a boyfriend, on whom she became increasingly dependent for reassurance and companionship when she went on the street or into stores. Any street situation reminiscent of her rape was especially frightening. In spite of her fears and panic attacks, she had been able to continue the half-time job that she had had before her victimization.

Immediately after the rape she had received some crisis counseling and had been given low doses of diazepam (Valium) to take as needed for her anxiety. She was concerned about the side effects of medications and was reluctant to take them. On the other hand, as the weeks went by her symptoms became so persistent and oppressive that she began to entertain the possibility of suicide. In desperation, she came to the clinic and agreed to a trial of medication.

The initial workup included a medical history, physical examination, electrocardiogram, and blood tests in addition to the psychiatric diagnostic interview. She met DSM-III criteria for panic disorder. Depression was evident also in her expressions of hopelessness and helplessness, in her suicidal ideas, and in her rather frozen facial expression in the interviews. She had also recently developed a fear, fluctuating in severity, that her food might be poisoned, an idea she recognized as unrealistic, but which had such power that at times she could only be reassured by her boyfriend eating a bite of her food first.

Her panic attacks were made the focus of treatment. She was started on regular doses of alprazolam (Xanax), beginning at 1 mg/day, and increasing over two weeks to 6 mg/day, divided into doses every four to six hours. Although Food and Drug Administration required labeling recommends a maximum daily dose of 4 mg, one clinical study indicates that optimal treatment of panic disorder requires a mean daily dose of 6 mg and a maximum of at least 9 mg (Sheehan, 1982b). Her fear of poisoning manifested itself at the beginning of treatment by her having her boyfriend ingest one of the alprazolam tablets first to assure their safety. After two weeks of treatment, her panics and chronic anxiety had abated greatly, but not completely. Panic attacks continued to occur every few days. The patient's fears of poisoning were much reduced. The alprazolam initially made her sleepy during the day, but this sleepiness gradually disappeared, even though the dose was increased. She was encouraged to practice going places without her boyfriend in order to get over her fear of walking alone. She was taught not to



leave situations in which she became anxious, but to wait until the anxiety subsided. As her condition improved, she began expressing the idea that she would like to leave her boyfriend and start a new life. She began to fight with him. He informed her psychiatrist that he had found her easier to get along with before her treatment.

Trying to eliminate all of the patient's panic attacks, the psychiatrist increased her daily dose to 8 mg. Her attacks ceased, but her alcoholic mother called him to complain that her daughter's personality had changed for the worse. Instead of being agreeable, her daughter was refusing her advice and insulting her. The mother wondered whether this was a side effect of the medication, whether it was addicting, and whether the medication could do permanent harm. The patient's boyfriend reported that he had noticed that the patient had begun to have occasional episodes of staggering and slurred speech. The patient herself told the psychiatrist, with no signs of slurred speech, that she was having no problems with the medication and implied that her mother and boyfriend were invested in her being sick again. She was examined and no nystagmus or ataxia was detected. Her blood pressure and pulse were normal. In spite of these negative findings, the psychiatrist, with the patient's consent, reduced her alprazolam to 6 mg/day.

After two months at this dose, during which the patient felt well, optimistic about her future, and had only a few tinges of what had previously been panic attacks, she and her psychiatrist decided to try to reduce the dose further. Tapering it at the rate of 0.5 mg every three to four days was successful down to a dose of 3 mg. At that point, the panic attacks returned in full force, and the patient declared herself to be more anxious than she had ever been before. The dose was hastily increased and the anxiety was relieved again.

Several of the ambiguities of drug therapy are illustrated by this vignette. One is whether drug treatment should have been started in the first place. Perhaps individual and family psychotherapy could have obviated the need for medication entirely. A vigorous behavior therapy program of exposure to feared situations also might have alleviated the panic attacks. Second, even if drugs were indicated, it is not clear that the right one was given. The patient had symptoms of anxiety, depression, and a fear of being poisoned that was almost delusional. Arguments could be made for treating the patient with imipramine or haloperidol instead of alprazolam. Since depression was such a prominent feature, imipramine might have had an advantage over alprazolam since imi-



pramine can treat both panic attacks and depression. In defense of alprazolam, it should be pointed out that alprazolam also has antidepressant as well as antianxiety properties, is faster acting, has no anticholinergic side effects, and is less likely to produce paradoxical exacerbations of anxiety. On the other hand, haloperidol or another antipsychotic might have been the drug of choice in view of the near-delusional fears of poisonings. Severe anxiety of the type the patient experienced may have been a sign of an impending schizophrenic break, and the patient's lack of affectivity, less depression than flattened affect. In defense of the choice of alprazolam over an antipsychotic, the specter of tardive dyskinesia could be raised.

The central problem with drug therapy is balancing symptom relief with negative drug effects. At higher alprazolam doses, the person closest to the patient felt the drug was producing an intoxication. Although his report could be faulted as biased, it was sufficiently worrisome to cause a reduction in dose, especially since alprazolam is relatively new and was originally prescribed in lower doses. In addition, enthusiasm for the short-term benefits of the drug is often tempered by the long-term disadvantages. In this case, it is unclear when the patient will be able to stop the medication. Although alprazolam does not appear to be addicting in the sense that patients want to increase their doses, it does produce a severe withdrawal reaction if stopped too quickly. When it is tapered slowly and anxiety returns, it is often unclear how much of that anxiety is due to drug withdrawal, an uncovering of a still-active anxiety disorder, or fear at a symbolic, interpersonal level.

Finally, our case illustrates that changes produced by drugs in one person have repercussions throughout his or her social network. Relief from anxiety made the patient see her former social adjustment as bondage to the desires of her mother and boyfriend. They reacted unfavorably to the "new" her. It is unclear whether a break from her current attachment figures would have led to a better, more liberated life adjustment or to a negative outcome, such as guilt and social isolation or a frantic search for substitutes that would prove to be equally unsatisfactory.

The uncertainties illustrated by this vignette are altogether typical for finding the proper role of medication in post-traumatic therapy. A narrow focus on drug treatment alone can miss important forces operating for stability or change, forces that a more comprehensive therapy might harness. Instead, attention must be broadened to include a good under-



standing of the thoughts, feelings, and social adaptation of the victim, the reactions of significant others, the victim's physical health status, and the pros and cons of a variety of psychotherapeutic and pharmacological interventions.

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## *Healing of the Whole Person*

MARY R. MERWIN and BONNIE SMITH-KURTZ

Victims of violence suffer more than a physical assault. Injuries are inflicted on the mental, emotional, and spiritual self, as well. When treatment of one of these wounds predominates, such as medical care for physical injury or psychological counseling for emotional trauma, healing of the whole person may not occur. However, a treatment program directed toward total healing and wellness will marshal all available forces, attitudes, and techniques to speed total recovery. The creation of an environment conducive to healing will stimulate all the recuperative and regenerative powers of an individual.

A fractional approach to the recovering individual may suppress unbearable symptoms; for example, treating a victim's insomnia with hypnotics will temporarily alleviate sleeplessness. A wholistic approach minimizes the need for both passive and invasive treatments by adding self-healing techniques. Insomnia may be treated with imagery, behavioral techniques, relaxation, and exercise. This approach does not disallow the use of medication. However, emphasis is placed on helping people understand and help themselves, on education and self-care, rather than dependence on an "expert." Wholistic attitudes incorporate the best of the biomedical armamentarium into a broader context. Particularly with victims of violence, such an approach engenders the necessary regaining of control of one's life and one's person, of self-esteem, and of trust in oneself. These psychological changes, as well as the physical and spiritual recovery, are part of the growth from victim status to survivor status.



For some victims, brief immersion in a total, residential program may be most appropriate; for many others, this environment can be created by the client and the therapist on an outpatient basis. In this chapter, we shall discuss what we believe to be a beneficial format for outpatient work with victims of violence, stressing five areas to be included in a total approach to recovery: nutrition, physical activity, spirituality, humor, and stress management. Suggestions and resources will be provided for each.

### THE FORMAT OF POST-TRAUMATIC THERAPY

In addition to the wholistic approach to healing and recovery advocated in this chapter, post-traumatic therapy (PTT), as outlined in the introductory chapter of this volume, is based on a set of approaches we consider appropriate and beneficial for work with victims of violence. They bear reiteration. PTT presupposes no psychopathology prior to the victimization, emphasizes coping skills and strengths of the client, forthrightly asserts that the victim is not to blame, aids in elimination of misconceptions and self-defeating behaviors, and proceeds within a context of a partnership and parity in respect and power.

The Dimondale Center, originally described by Ochberg and Fotjik (1984), follows a format that is essentially transferable from the residential setting to outpatient work. The model of care is wholistic and based on the concept of stress reduction. The therapeutic program consists of four elements: physical fitness, education, psychotherapy, and social integration. The purpose of physical activity, whether in a residential or outpatient setting, is to reintroduce the victims to their physical bodies in a manner that fosters appreciation and acceptance and enhances a feeling of physical well-being. The education program at Dimondale includes several individualized components, such as relaxation techniques and biofeedback; assertiveness training; and information on the civil and criminal justice systems, victimization, and the sociopolitical community response. Psychotherapy includes both individual and group modalities, and family therapy, if appropriate. Social integration is fostered first within the program and later in the community as the clients' residential stay nears an end. In addition to reintegration with family and friends, contacts with self-help and support groups are provided.

Ochberg and Fotjik (1984) stress that the client must assume an active role of participation and decision making throughout therapy. The



overall goal of post-traumatic therapy, whether conducted on an in-patient or outpatient basis, is for the victims to become survivors, to reassume control and mastery of themselves, their resources, and their lives. The therapist supports and encourages, provides needed information, guides, and facilitates.

The four elements of post-traumatic therapy at Dimondale are part of the approach recommended here for outpatient work with victims, as well. In addition to the clinician's usual role in psychotherapy, one needs to educate, consult, encourage, and/or refer the client for assistance in the areas of physical exercise, nutrition, social integration, and spirituality. One also finds that the five paradigms for clinical work elucidated in the introductory chapter become interwoven throughout the wholistic approach. For example, the person who has been held hostage, assaulted, or raped (what Ochberg calls negative intimacy) often feels defiled and disgusted by her or his own body. In addition to examination and discussion of these feelings in detail during therapy, exercise can be used to recover a positive body image. The victim who has lost the veil of denial and is experiencing death imagery can be helped not only through therapy, but also by tapping into his or her reservoir of spiritual strength. A victim who is assailed with images of the very real chaos and injustice of the world may also be able to realistically appreciate its beauty.

## PHYSICAL ACTIVITY

Following severe trauma, even those who may have engaged regularly in physical activities prior to the victimization may find their daily routines too disrupted, their health too compromised, their emotions too shattered, or their energy too diminished to include any significant exercise in their daily routine. We believe it is very important to introduce daily physical activity back into their lives as soon as possible. This will both discharge energy and reintroduce the victims to their bodies in a way that will lead to increased appreciation and acceptance. An enhanced sense of physical well-being counteracts depression and self-deprecation and possibly aids in the physical healing of wounds. Physical activity is a well-known coping mechanism for managing stress.

We do not necessarily recommend a rigorous training program, although for some people this would be appropriate. What helps almost everyone (with consideration of physical injuries and consultation with the victim's physician) is encouragement to take a few minutes each



day for gentle stretching or yoga and an effort to get out for some brisk walking. The walking may be done either as a means of getting places or, better yet, as a timeout from the day, to enjoy nature, talk with a friend, find a sense of calm. Spending part of a therapy hour walking with the victim is an unobtrusive and supportive way of modeling and encouraging this. We wish to emphasize that while suggesting stretching and walking, the routine must be individualized, and the victim should be actively involved in considering alternatives and deciding what to do.

The reasons for emphasizing physical activity as a part of the healing process are many and varied. The benefits of exercise as a means of stress reduction are well known. Exercise is a valuable tool to allow one's mind time for a "break" as the rational, problem-solving brain is temporarily quieted by the body in motion. Obsessive rumination and intrusive recollection are diminished. Both exercise and meditation contain a point of focus. Gradually, this focus frees the mind as the body moves or relaxes, letting go of pent-up emotions and finding a temporary serenity.

The principle of putting the victim back in control of his or her life and body applies here, also. Recognizing the benefits available, deciding for herself or himself what would be pleasurable and how to fit it into the day, beginning and continuing the effort are all active behaviors that imply "This is *my* life," "I can make decisions," "I can do things that are good for me." Although the immediate aftermath of victimization may not be the best time for a person to learn new physical or social activity, once crisis resolution has occurred and the person begins to pick up the threads of her or his life, a fresh activity is a means of moving on, of putting the trauma behind one, of moving from victim to survivor status.

Many victims are under the care of a physician and a physical therapist while recovering from injuries. Providing support to the client to aid compliance with a physical therapy regimen is an important role for the therapist. In this regard, good communication between the therapist and the medical professionals is essential.

Physical activity can also serve as a nonthreatening socialization medium, leading to increased social integration. If a person joins an exercise group, a sports class or team, or a health club or uses public community facilities, contact with others occurs automatically and in a safe and defined setting. The amount of interaction can be controlled by the person. For those with fears of reentering the social world, these settings can provide a gradual and less threatening means of contact with the public, at a personally chosen pace.



Therefore, for most victims, assistance and support in developing a well-rounded daily fitness routine are appropriate. The therapist's role is to provide basic education regarding tenets of proper exercise, to help the victim identify and choose alternatives, and to provide support and encouragement for learning and maintaining activities. As victims are moving toward survivor status, the therapist has an excellent opportunity to help them make basic life-style changes. These are self-affirming and are associated with resumption of control over one's life.

Techniques of physical training have changed in recent years as the maxim "no pain, no gain" has been discarded. Exercising past the pain threshold risks injury to muscles, joints, or tendons. The watchwords today are "balance," "moderation," and "listen to your body." Persons who pursue fanatical training programs are doing so for reasons other than just physical and psychological health.

Almost all experts in the field now favor moderate exercise and gentle non-joint-pounding activities, such as swimming, rowing, walking, and cross-country skiing, rather than excessive running or aerobic dance. If running is preferred, good shock-absorbing shoes and moderate distances are recommended. Proper shoes, a shock-absorbing floor, and a well-trained instructor are important when aerobic dance is chosen. We caution people against aerobic dance programs that do not follow the warm-up, aerobic activity, stretching, and cool-down format described below. Movements such as deep lunges (with the knee extending ahead of the foot) or deep knee bends (with hips dropping below knees) or insufficient attention to counteracting muscles (such as hamstrings, which counteract the quadriceps) are all indications that a particular program is not based on the latest knowledge of exercise physiology. The risk of injury is greater in such a program.

Some people who enjoy aerobic dance are turning to a low-impact form, where one foot always remains on the floor and which may include influences from T'ai Chi, aikido, or yoga. Water aerobics, which are easier on the joints and eliminate quick turns and jerks, are now offered in many localities.

The most rapidly growing exercise activity is walking. It is gentle on the body, with almost no risk of injury; it does not require special training, expensive gear, or membership fees; it can be done anywhere; and the effort can be increased as cardiovascular fitness increases. Walking clubs are forming, and there is even a new periodical called *Walking Magazine*.

It is very important in introducing exercise into one's life-style that it not be viewed as something one *should* do, but rather as something one enjoys and wants to do. It must, therefore, always be individualized



and the choice of the client. It is helpful for the client to delineate the reasons for wanting to be more fit and to set reasonable, reachable short-term goals.

Physical fitness is generally considered to consist of three elements: strength, cardiovascular efficiency, and flexibility. A well-rounded exercise program will include all three and will *always* begin with a warm-up period. Contrary to popular belief, this does not mean stretching. Cold muscles should never be stretched. A series of calisthenics begun gently and increased in vigor as "warming" occurs is an appropriate start. They should be done until one is not just warm, but hot enough to have broken a light sweat. Warm-up activities include such exercises as bicycling (on an exercise bike or the old-fashioned way on the floor with one's legs in the air), jumping jacks, and running in place. Most activities vigorous enough to warm one without requiring extreme stretches are appropriate.

Once one is fully warm, one can begin strengthening exercises. Strengthening exercises are those done against the resistance of gravity, often with weights. Working on weight machines should be done only with instruction, and if one is using strap-on weights at home, it is important to begin with low weights and few repetitions. With appropriate weight, three sets of 10 repetitions/set are sufficient for any muscle group. Sit-ups fall in this category, and they should *always* be done with bent knees. It is not necessary to come up all the way into a full sitting position, for the greatest effort is required at the beginning, and rising further can strain the back.

Aerobic activities condition the cardiovascular system, increasing the efficiency of the heart in carrying oxygen throughout the body. For conditioning to occur, one must engage in activity that brings the heart to its "target rate" for 30 minutes three to four times per week. People calculate their maximum heart rate by subtracting their age from 220. The target rate is 70-80% of the maximum. It is important for a person to be able to take her or his pulse to assure the rate is fast enough for conditioning, but not above the target rate. More and more recreational athletes are turning to "cross-training," engaging in more than one sport for conditioning. This is more likely to give total conditioning, taxes specific body parts less, and provides variety to keep up interest. Following aerobic activity, cooling down is as important as warming up beforehand. Now, while your muscles are hot, is the time to stretch, beginning gently with an easy stretch and increasing the intensity as you hold. Never bounce! A sustained stretch, breathing deeply and increasing the stretch on the exhale, is more beneficial and less likely



to result in a pulled muscle. Relax and concentrate on the muscles being stretched. Do not stretch to the point of acute pain. Stretching after activity minimizes muscle soreness by accelerating the elimination of lactic acid accumulated in the muscle and by preventing the muscle from tightening up as it cools.

Physical activity can benefit everyone. However, it is especially helpful to victims in the process of total recovery from trauma. The benefits are physical and psychological, and each affects the other type of healing. Physical healing and improving fitness positively affect one's feeling about the body, particularly if the violence perpetrated produced feelings of defilement. Self-esteem rises, and these more positive attitudes are, in turn, beneficial to the physical healing from wounds and injuries.

## NUTRITION

At a time when emotional stress and physical injuries have increased their nutritional needs, many victims demonstrate poor nutritional habits. They may be unmotivated to eat, finding lack of pleasure in this activity or outright revulsion. Others may overeat, using food as a means of relieving tension. And the food that is eaten is frequently processed, convenience foods, which are generally high in fat and sodium content and low in nutrients. Though easily available, these highly processed foods do not adequately meet the nutritional needs of a body that is physiologically stressed. The result is often nutritional bankruptcy which delays the healing process. Joseph Wilder (in Adams and Murray, 1973), a New York specialist in psychiatry and neurology, has noted that in adults faulty or insufficient nutrition may alter or impair specific or general mental functions and eventually cause structural damage of the central nervous system. The 1984 Symposium of the American Society for Clinical Nutrition on Nutrient Intake, Brain Biochemistry, and Behavior reviewed research findings on the effects of diet on behavior. According to Pollitt and Read (1985), "the neurochemistry of the brain, and the associated cognitive processes, can be affected by nutritional deficiencies and by both the constituents and scheduling of diet" (p. 348).

### *Effects of Sugar*

Not every clinician who treats victims of violence feels comfortable giving information on nutrition. But a few basic facts are easy to master and useful to know.



A high intake of foods and beverages containing sugar, as found in the Standard American Diet (SAD), provides calories but few nutrients. According to studies done by the U.S. Department of Agriculture, the average American eats over 120 pounds of sugar each year. It is estimated that over two-thirds of the sugar consumed in the United States is used in the processing of foods for the purpose of sweetening, improving foods' texture and appearance, and improving the shelf life of processed foods by preventing spoiling and helping foods retain moisture. Sugar that is "hidden" in processed foods dramatically increases the amount of calories consumed as this nonnutrient food item. For example, each tablespoon of processed peanut butter includes approximately  $\frac{1}{2}$  to  $\frac{2}{3}$  teaspoon of sugar. A tablespoon of ketchup contains approximately 1 teaspoonful of sugar. One-fifth of the refined sugar consumed by Americans is in the form of sweetened soft drinks. Since sugar is absorbed directly into the bloodstream, requiring an immediate response of insulin from the pancreas, the endocrine system is stressed at each sugar-loading session. "Insulin overshoot," the overproduction of insulin in response to a sugar load, can cause healthy people to develop considerable fluctuations in blood sugar, including hypoglycemia. The symptoms are feelings of weakness, shakiness, headache, mental dullness, confusion, nausea, and faintness. Hunger accompanying the drop in blood sugar level may precipitate consumption of more low-nutrient, sugared foods and continue to aggravate the problem.

Refined sugar lacks food factors needed for its metabolism by the body, causing a loss of vitamin B<sub>1</sub>, B<sub>2</sub>, B<sub>6</sub>, niacin, magnesium, and cobalt as the body draws on its reserves to metabolize sugar. If the sugar is not completely metabolized, a buildup of lactic and pyruvic acid may develop, leading to tissue degeneration. Loss of B vitamins can directly affect the functioning of the nervous system, as well as affecting the body's ability to assimilate other nutrients. Calories from sugar frequently take the place of other calories from food sources of nutritional merit, further depleting the body's energy reserves.

Brand et al. (1985) cited a recent study from the University of Sydney examining the effects of consumption of highly processed foods on human blood sugar levels. These researchers found that processed foods, such as rice cereal, corn chips, instant potatoes, corn flakes, and instant rice, produced a rise in blood sugar levels far greater than that caused by unprocessed foods. With the rise in the body's blood sugar levels, there is increased demand for insulin production and the possibility of erratic blood sugar fluctuations with corresponding physiological and mental symptomatology.



### *Processed Foods*

Excessive processing of foods not only lowers nutritional value, but increases concentrations of salt, sugar, fats, and a wide assortment of artificial ingredients, additives, and preservatives. A quick trip through the local supermarket or fast-food restaurant reveals a plethora of brightly packaged and attractively displayed food products of questionable nutritive value. More than half the foods in the SAD are processed and packaged foods that did not exist a decade ago.

It is worth taking some time to examine the relationship of these highly processed foods to major and minor health problems in the United States. An estimated 30 million Americans suffer from cardiovascular disease, with approximately one million dying yearly. Both the American Heart Association and the U.S. Department of Agriculture recommend that a person's total intake of fat be limited to 30% or less of all calories in the diet. However, Americans presently obtain over 40% of their calories from fat. Processed foods maintain this high percentage of fat in the SAD. A lunch of one Big Mac, one order of regular fries, and a vanilla milkshake has approximately 1,145 calories, 42% from fat (American Heart Association, 1986). Most processed luncheon meats contain approximately 75% of their calories in fat. Most cookies, crackers, cakes, and doughnuts contain 35–50% of their calories in fat. Potato chips and other snacking chips average 65–80% fat calories. A fast-food breakfast of egg and biscuit with sausage may contain 50–70% of its calories as fat.

Besides being high in fat content, processed foods are frequently high in saturated fat. This type of fat in the diet is linked to increases in blood lipid levels, with corresponding increases in risk of developing cardiovascular disease. Saturated fats, including animal and some vegetable fats, palm and coconut oils, are found in many processed foods, from items found in fast-food restaurants to coffee whiteners found on grocery shelves.

### *Caffeine*

Emotional pain, which may lead to eating out of anxiety, use of food as a method of self-nurturance, or a complete disinterest in food, can also lead to an increased use of the drug caffeine. Not only found in coffee and tea, caffeine is added to soft drinks in the United States at the rate of approximately two million pounds per year. It is also found in candy, baked goods, processed puddings, frozen dairy products, and



medicines. In vulnerable individuals, excessive caffeine causes a syndrome resembling panic attack, with symptoms including restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal complaints, cardiac arrhythmia, muscle twitching, rambling flow of thought and speech, periods of inexhaustibility, and psychomotor agitation (APA, 1980). In addition, caffeine can potentiate the adverse side effects of some medications and is potentially toxic when used to excess or with other drugs. In light of this information about caffeine, it is interesting that the first thing some therapists do is offer their clients a cup of coffee! How much better we would do to offer a glass of unsweetened fruit juice, decaffeinated coffee, or decaffeinated tea.

### *Dietary Review*

It is generally agreed that a body under physical and emotional stress has increased nutritional needs, and victims may have little motivation or ability to satisfy the body's needs at this crucial time. We recommend that a brief dietary review be done with each victim. This review should include an assessment of the client's diet prior to the victimization and the present diet. Satisfaction with the present diet should be assessed, as should the client's assessment of areas of deficiency. The dietary review may be used to assess the victim's knowledge of basic nutritional facts, as a tool to provide new information and to emphasize the importance of proper nutrition, especially for one under stress. Current weight trends should be noted in the assessment. In addition to the common reasons for dietary deficiencies, such as appetite loss, there may be a problem such as fear of going out to shop. This sort of problem clearly needs to be addressed or all the information provided will be of no help.

In a residential setting, the staff can help clients maintain an adequate diet until they are able to fully take over this task for themselves. An outpatient therapist could help arrange for friends or relatives to provide food for a period of time. One well-placed phone call could prompt the loving support of family and friends in bringing in meals, as so often happens in our culture when we experience death in a family. Victimization is often as traumatic as bereavement, but we have no accepted ritual of family support. The therapist, with the concurrence of the client, can communicate with the client's supportive friends and family and use the opportunity to provide them information about the effects of victimization.

We encourage the fairly rapid resumption of self-care on the victim's



part, with support and assistance, as needed. Resuming and reshaping the tasks of daily living are ways for the victim to regain control and return to a normal routine. Purchasing, preparing, and consuming food are significant features of a daily routine. When done with support and awareness, these acts can help in regaining an appreciation of the world and of life by breaking through the numbing and emotional constriction that may have occurred following victimization. They can also provide excellent opportunities for social integration with family or friends.

### SPIRITUALITY OR BECOMING FULLY ALIVE

Just as a victim's physical or emotional senses may be numbed, so may the spiritual sense. By spirituality we are not necessarily implying religious activities and concepts, although organized religions and their belief systems are a source of spiritual strength for many people. We use the word in the sense of its Latin origin, *spiritus*, meaning breath, life, alive. Spirituality is a state of being fully alive and open to the moment. It includes a sense of belonging and of having a place in the universe. A deep appreciation of the natural world, an openness for surprise, a gratefulness for the gratuity of everything, joy and wonderment are all a part of spirituality. Although spiritual growth is a type of healing from which most of us could benefit, a victim's sense of spirit may be acutely dimmed for a period after the victimization.

Over time, however, as the victim heals in all areas, the potential for spiritual growth may become greater than ever before and greater than for many people who have not faced the reality of their individual death. We are all familiar with people who have experienced life-threatening situations such as disease or accidents, and who afterward found renewed zest and *joie de vivre*. Br. David Steindl-Rast (1984) has stated that "the fact that you are not yet dead is not sufficient proof that you are alive" (p. 191)! He goes on to say that to be fully alive requires the courage to face death. A victim of violence may have an all too clear image of his or her biological death. This death imagery may foster strong, perhaps overwhelming, and ongoing fear. Finding and rekindling a victim's memory of spiritual experiences when she or he felt connected to all things, a part of the universe, and a belongingness to God (however the individual may conceptualize this) provide the strength for facing and working through death imagery. This can be a difficult search, and we encourage the therapist to call on the assistance of "spiritual professionals" for consultation. When the victim has a



positive relationship with a minister, rabbi, or priest, from whom she or he is obtaining support, we recommend that the therapist discuss the trauma of victimization and its aftermath with this individual, to avoid any possibility of the "second wound," and to reach consensus about the spiritual dimension of post-traumatic therapy. To the extent that a victim has faced death, and worked through the death imagery, she or he may be opened up for fuller life. Fear of death can prevent us from being fully alive, just as fear of loss can prevent us from fully loving and giving of ourselves to others.

Although victims' fears, feelings, and beliefs are likely to be considered in psychotherapy, we recommend that as healing progresses, the therapist and victim examine specific experiences to foster the opening up to fuller aliveness. We believe a good place to start is by reawakening the appreciation of simple, daily pleasures through our physical senses. Here the quest for renewed spirituality can include items previously mentioned. For example, let us return to the issue of adequate nutrition. Therapists can help a victim redefine mealtime as a time of planned relaxation and reawakening of the senses, especially sight, smell, and taste. This will reinforce the effort of preparation, encourage better nutrition, aid digestion, and foster again finding pleasure in the act of eating. We recommend that the person specifically "change gears" before beginning the meal. Take a few moments to relax and shut out distractions by perhaps closing the eyes and focusing awareness on the breath. Take a few deep breaths to aid relaxation, and while still keeping the eyes closed, focus on the aromas of the food. Try to pick out individual scents and then see how they mix, like colors on a palette. As you begin to eat, savor each mouthful, becoming aware not just of taste, but also of texture. Such a meal should be eaten in a comfortable environment, with pleasant lighting, perhaps with music, or whatever will make for a sensually full and satisfying experience. This may also provide an opportunity for social integration.

Many other activities can be opportunities for developing our spiritual and physical senses and for developing a childlike wonder and joy and surprise about the world. The daily walk which was suggested above can be used for sensing, especially hearing. Whether in the woods, on a beach, or on a busy city street, there are a myriad of sounds. Try to listen and really hear, while turning off your mind, which is saying, "That is the wind in the leaves" or "Now I hear a bus." Try not to identify and label, but merely experience the sounds, individually and as they mix and synergize. For victims with a fear or dislike of being touched, ask them to walk barefoot and focus on the changing textures



beneath their feet. Walk near trees and bushes and let *them touch you*, rather than you touching them. This requires giving up some control and allowing oneself to be slightly vulnerable. While the victim is actively regaining control over her or his life, this is a safe, non-threatening way of being touched.

We also recommend the use of poetry and inspirational writings. If we as individuals explore this area and find some favorites, these may be shared with the client. Support needs to be given for their explorations, as well. We've included a few of our favorites at the end of the chapter.

Although meditation is widely recommended for relaxation and stress reduction, Benson (1979, 1984) recommends utilizing an individual's spiritual beliefs to augment the positive results of meditation, or what he calls the "relaxation response." When, instead of using a neutral word for the focus of meditation, a person chooses a phrase with personal religious meaning, it becomes prayer. Benson has found that some people who have difficulty "meditating" may have no difficulty "praying." Certainly the phrase must be appropriate to the individual's particular religious beliefs, such as a line from the Hail Mary for Roman Catholics, any of Jesus' teachings for Protestants, a Hebrew word such as "Shalom" or "Echod" for Jews. In a broader sense of religion, any phrase that represents a part of the individual's world view and belief system will suffice, whatever its source. It may be a line of poetry or prose or a phrase the individual creates. The essential factor is belief in the meaningfulness of the words spoken, what Benson calls the "faith factor." Such a meditative practice harnesses not only the healing effects of relaxation, but spiritual strength, as well.

## HUMOR

Victor Borge called laughter the shortest distance between two people. Although humor and laughter are among the most prevalent forms of human social behavior, humor as a therapeutic medium is one of the least studied and understood. Although it is generally accepted that humor improves the quality of our life, enhancing communication and providing therapeutic benefits, its use as a therapeutic tool by professionals is sadly limited. We know that happy, positive-minded people generally respond better to treatment than do cheerless, fearful people. The findings of Norman Cousins (1979) stressed the benefits of therapeutic use of humor. Cousins maintains that laughter promotes recovery



from disease by providing a safety valve for releasing negative feelings, such as frustration, helplessness, and anger, which can impede the physiological process of tissue repair. He called laughter a form of "internal jogging," which produces both psychological and physiological benefits. Cousins described his victory over a connective tissue disease with the help of a steady diet of humor: "Ten minutes of genuine belly laughter had an anesthetic effect and would give me at least two hours of pain free sleep" (p. 39). Supporting his observation, research suggests that laughter releases endorphins, morphinelike substances in the brain that cause pleasure and relieve pain.

Humor used as a healing tool has long been recognized. In many early societies, an element of jest and caricature often intruded into the most sacred rites, as a measure of exorcising some of the awe of the ritual mystery through comedy. Consider the clownlike figures of Hopi ritual dances, which interrupt and poke fun at the dance. Early Greek theater included comic caricatures in grinning masks, which were a central feature in the plays. In the early centuries after the birth of Christ, court jesters represented a safety valve in feudal society, the "innocent" who could answer back and poke fun at anyone. They enabled tolerance of sharp comments on contemporary society. Court jesters were able to make very pointed political remarks without losing their heads (literally!). Humor has long been used to reassure, to make problems of the world more manageable, to convey feelings of warmth and confidence, and to bring people in groups closer together. Humor restores energy needed to survive and deal with the realities of life.

A review of modern medical and psychological treatment modalities shows little planned use of humor. Although professionals voice acceptance of the importance of humor in aiding the reduction of life's stressors, laughter and jokes have usually been considered "unprofessional" behavior in work situations. Also, being disabled, ill, or under stress is not usually considered a funny situation. Caregivers often feel uncomfortable when they encounter tragic situations. This discomfort may cause them to avoid use of humor in a therapeutic setting, despite obvious benefits. As Cousins pointed out, humor facilitates the use of a positive belief system to allow the individual's own regenerative and restorative forces to work. Numerous studies have been conducted on the physiological benefits of laughter, including one that has been conducted for over 25 years by William Fry, Jr. (1977), at Stanford University Medical School.

Physically, a good hearty laugh triggers many reactions throughout the body:



1. The heart rate increases, with improved circulation of blood.
2. Catecholamine secretion is stimulated, with elevated epinephrine levels. This causes increased alertness and sense of well-being.
3. The diaphragm is involved when you laugh a deep, hearty laugh, improving respiratory activity and increasing levels of oxygen in the blood.
4. The intercostal muscles and the muscles of the abdominal wall are exercised when you laugh. This results in an increased digestion rate, probably from massage of the internal organs.
5. The body temperature is raised approximately one-half degree, secondary to the increase in blood circulation with laughter.
6. There is an initial increase in blood pressure in anticipation of a joke's punchline, with a drop below baseline blood pressure immediately after the punch line.
7. Lacrimal ducts tear, causing eyes to "sparkle."
8. Skeletal muscle tone is diminished, giving deep muscle relaxation. Laughter's ability to cause muscle relaxation is of great value in reducing stress since muscle relaxation and anxiety are incompatible. A measurable decrease in muscle tension has been found to last up to 45 minutes after laughter.

Numerous psychological benefits are associated with the therapeutic use of humor. Humor can be an effective means of establishing trust between individuals and facilitating a more relaxed atmosphere for therapy to take place. Shared humor, as the sharing of feelings, decreases social distance between people. Since humor is a "two-way street," it allows both therapist and client to give each other the gift of laughter and sharing of feelings. It is an empowering emotion for both. Humor allows greater expression of feelings and is an excellent communication tool. Humor can be used to facilitate both therapeutic and learning processes by making the process enjoyable and increasing attention span. When a therapist broaches a particularly difficult subject with a client, humor may be used to defuse defense mechanisms that might otherwise interfere with the client's ability to address the painful topic. Warner (1984) states that "humor allows one to risk speaking of anxiety producing content in a safe, socially accepted way without fear of censure, allows pleasure for self and others and allows one to rise above and gain a sense of control over a problem area through laughter" (p. 19).

Humor may be used as a means of denying or avoiding feelings too



frightening to face. Often, the trauma of victimization is overwhelming, and painful emotion may be deferred through the use of humor. It is evident to most therapists that people undergoing a serious crisis often laugh or humor one another as a way to boost morale. This type of humor, sometimes called "black humor" or "gallows humor," was studied during World War II when individuals in Nazi concentration camps were about to face death (Obrdlik, 1942). Humor used in therapy must go beyond "gallows humor," enabling the victim to overcome merely defensive laughter. The role of the therapist includes modeling appropriate uses of humor.

For a person dealing with the dehumanizing feelings of victimization, humor helps in restoring the feeling of humanity in therapy. Dass and Gorman (1985) discuss openness to pain. They point to the possibility that the resistance to facing pain may be more painful than pain itself. They suggest that the therapist demonstrate that what is imagined to be unbearable is potentially bearable. Ram Dass uses gentle humor in the form of the clown "Wavy Gravy" to aid others and himself in dealing with pain and suffering. To share pain and suffering is an intimate act between therapists and victim. The sharing may be facilitated as humor "plays with pain," offering opportunities to face and gradually accept painful experiences. Consider "Wavy Gravy's" use of clown makeup to transform the bald head of a young leukemia patient into a backdrop on which to show a movie, pleasing both patient and friends and bringing all involved a step closer to bearing the unbearable.

Both therapist and victim should realize that it is not necessary to be happy to laugh. In fact, if people believe they must be happy to laugh, they deny their pain, since to trigger laughter we play with pain. It is acceptable to feel bad because it is acceptable to *feel*. Through humor, therapists aid victims in reducing emotional constriction.

Humor and laughter are among the few socially acceptable means of releasing pent-up frustration and anger. In the early 1900s Freud (1905, 1923) referred to humor as a cathartic mechanism for preserving psychic or emotional energy that would otherwise be released through negative emotional responses. Humor allows the victim to display anger, hostility, aggression, and fear in a socially acceptable way. Warner (1984) suggests that humor is a form of self-disclosure. Through humor, therapists gain important clues about people's anxiety, concerns, sense of self-esteem, and feelings of inferiority. It has been said that jokes go best on the graves of old anxieties. Humor is used to make these anxieties a little easier to face and to offer the therapist a means of restoring a victim's perspective in identifying and dissipating anxiety.



Zwerling (1955) suggested having clients tell favorite jokes, using this technique to reveal areas of anxiety and conflict.

Robinson (1977) quotes Nietzsche: "Man alone suffers so excruciatingly in the world that he was compelled to invent laughter" (p. 59). Robinson affirms in her book that humor is one of the most valuable tools a health professional can have and gives guidelines in utilizing humor in communication, teaching, and intervention. She stresses that humor is an "attitude" that must be developed and practiced if it is to become an integral, spontaneous treatment modality.

There are some basic rules for therapeutic use of humor. Be selective with your use of humor, using sensitivity to what is appropriate to the situation. A therapist should know the client well enough to evaluate whether the humor will be understood and the message conveyed will be acceptable. Fry (1963) recommends that the therapists make it very clear that they are joking and that the intent is to be taken as humorous, especially when humor is used in a nonhumorous setting. Cues that signal a change in the type of therapist-client interaction precede use of humor and prepare the client for its use. These cues may include nonverbal messages such as a change in facial expression or a gesture, or verbal communications such as a change of voice tone or an introductory statement such as "this reminds me of a cartoon I once saw" (Fry, 1977, p. 161). Humor should never be used to put anyone else or oneself in a disadvantaged position. "Put-down humor" is not therapeutic. Therapists using humor must be careful to understand that although you play with your own pain in humor, you do not play with other people's pain. Therapists should not be sarcastic, and sarcasm encountered in therapy should be addressed directly and discouraged.

If the victim can weep, she or he can laugh. Often men will find it more difficult to weep than women because of cultural sexual stereotyping. Those who find it difficult to cry may also find it more difficult to laugh. They may hide their feelings behind sarcasm or self-deprecating statements. It is beneficial for the therapist to address these defense mechanisms directly to enable a person to develop fully.

Where do therapists begin to develop a sense of humor and the ability to use it in a therapeutic manner? We recommend that therapists make an assessment of their ability to see humorous situations in everyday life and assess what types of humor seem to work best for them. There are some excellent periodicals and other resource materials on this subject, many of which are listed at the end of this chapter. It is important to realize that, as with any therapeutic mode, use of humor takes practice and can be thoughtfully developed.



In the book *The Laughter Prescription*, Peters and Dana (1982) give useful suggestions about developing a sense of humor. They encourage adopting an attitude of playfulness which enables one to be open to the humor in everyday life in an uncensored, childlike way. They suggest that one attempt to see problems from a different perspective, searching for the funny or flip side of every situation. Rather than being annoyed and angered by the incongruities in life, learn to laugh at them. Learn to laugh at yourself in a nonjudgmental, accepting manner. When you are able to laugh at your own weaknesses or mistakes, you become more open to others. This opens lines of communication as vulnerability is shared. Peters notes that "you can take almost any disagreement, any wrong or injustice, any gripe of difficulty and use humor to change things for the better" (p. 147).

Keeping a humor journal or a file is an excellent way to increase one's sense of humor and provides an enjoyable pastime. In this journal or file, keep the special things that you find humorous and lively. Review this on days that you need a "lift" or when someone around you would benefit from a bit of humor. Your humor file can be an excellent resource on days that your creativity needs to be stimulated. A good source of humorous material is a delightful quarterly periodical called *Laughing Matters*, edited by Joel Goodman. Consider having a "humor board," a place to display cartoons and other humorous materials. This type of bulletin board can do a lot to lighten the atmosphere in an office waiting room or allow the good-natured sharing of humor between people.

## THE PHYSIOLOGY AND MANAGEMENT OF STRESS

### *Stress and the Victim*

The concept of stress is biological, and an understanding of this will aid both the therapist and the victim in interpreting and reducing the symptoms of post-traumatic stress. The victim of violence should not view the post-traumatic experience as a sign of mental illness or a personal defect. First, the therapist must help the victim to understand that the myriad symptoms are the *predictable* reactions of a normal person who has been subjected to a unique type and intensity of stressor. The abnormal and terrible events have temporarily disrupted their equilibrium and fostered self-doubt, self-blame, and frightening



subjective experiences. These symptoms of post-traumatic stress have both biological and psychological bases. In addition, there are the psychological reactions that are unique to those who have been personally and violently victimized. An understanding of this complex array of factors can alleviate that portion of the victim's anxiety which derives from his conviction that he harbors abnormal thoughts, feelings, and behaviors.

Stress is the nonspecific response of the body to any demand on it (the stressor), to any internal or external stimulus (physical, mental, or emotional) that requires an adaptation of the body (Selye, 1956, 1983). A stressor is distinguished from other stimuli by the lack of an automatic restoration of homeostasis. Thus, whether a particular stimulus is a stressor depends on the meaning of the stimulus to the person and on the repertoire of readily available or automatic adaptive responses. A stressor is a demand that exceeds the resources of the system (Lazarus & Cohen, 1977).

The nonspecific adaptive response to the stressor is always the same, although it may vary in the degree of response depending on the intensity of the demand for adjustment. Selye termed the entire group of changes making up the nonspecific response the general adaptation syndrome (GAS). There are three stages to the GAS:

1. *Alarm reaction.* This initial response is considered to represent a general call to arms of the body's defensive reactions. The shock phase is the immediate response and typically includes such symptoms as decreased blood pressure and temperature, tachycardia, and loss of muscle tone. The countershock phase is a rebound reaction during which the adrenal cortex enlarges and secretion of corticoid hormones increases. Although the nature of the first mediator between the stressors and the response is not known, the hypothalamus is stimulated. It, in turn and by way of corticotrophic hormone-releasing factor, stimulates the pituitary to discharge adrenocorticotrophic hormone (ACTH). This hormone stimulates the adrenal cortex to secrete corticoids, which supply a readily available source of energy. Simultaneously, other hormones are secreted. Adrenaline makes additional energy available, increases heart rate and blood pressure, and stimulates the central nervous system.

2. *Stage of resistance.* The reactions here are quite different from, and often opposite to, those of the alarm reaction. This represents the adaptation of the body to the stressor. Symptoms may improve or disappear.



3. *Stage of exhaustion.* If the stressor continues at sufficient intensity for a prolonged period, the acquired and finite adaptation is lost. Symptoms reappear, and death may ensue. Selye points out that all parts of the body do not wear out at the same speed, and the pure stage of exhaustion is never reached. Rather, the weakest part of the body breaks down, causing general collapse.

As the chapters in this volume by van der Kolk and Roth ably demonstrate, symptoms of post-traumatic stress have both biological substrates and psychological meaning and usefulness. Van der Kolk cites evidence which indicates that many of the PTSD symptoms may be related to a continued state of autonomic arousal, as though the person is "stuck" in the first stage of the GAS, the alarm reaction. Adaptation characterized by the stage of resistance may have failed to occur. Roth points out that the PTSD symptoms may also be viewed as psychologically appropriate attempts at coping. They are part of the healing process of building a new balance or equilibrium, a part of adaptation to the stressor of victimization.

Victims of violence can be reassured by this knowledge, and proper therapy will take it into account in order to maximally foster healing on all fronts. Indeed, clinical work with victims requires the therapist to wear a variety of hats, regardless of professional discipline. As demonstrated in this chapter, the therapist must assume the roles of clinician, caseworker, coach, nutritionist, pastor, educator, comedian, and others. As necessary, the therapist must obtain consultation from or form a team with professionals of other disciplines, such as physicians, nurses, physical therapists, psychologists, priests, rabbis, or ministers.

The ties with medical professions are perhaps the most likely and necessary of these liaisons, particularly with victims recovering from injuries received in the assault. In regard to the use of medications, we agree with Roth that they are indicated when either the nature, intensity, or duration of a symptom is destructive to present coping and a long-term positive outcome; when there is substantiated reason to expect a particular drug to be helpful; and when the victim has been an active and informed partner in the decision.

#### *A Question of Balance*

The management of stress in our lives is essentially a matter of balances. Since life is an almost continual adaptation at some level, one cannot and, indeed, would not want to avoid all stressors. A



distinction must be made between eustress (or "good" stress) and distress. The former is necessary for health and growth, the achievement of goals, and fulfillment. Too little stress, boredom, and inactivity lead to atrophy of the physical body, mental acuity, emotional richness, and spiritual vitality. Thus, we seek a balance between hyper- and hypostress. We seek eustress and try to avoid distress. We attempt not to define or perceive neutral events as distressful. And we develop an individual armamentarium of coping skills to use when unavoidably presented with distressing events. All these approaches have their part in post-traumatic therapy, and it may now be apparent that the wholistic approach and content of this chapter are aimed at reduction and management of stress, of regaining salubrious balances. The therapist helps the victim regain a balance of nutrients, of physical activity and relaxation, gravity and levity, ego and outward directedness, solitude and togetherness.

The key to facilitating this for a person is individuality. The therapist's role is to educate regarding options, to teach skills that are needed, and to support generously the work of the victim-becoming-survivor. She or he must find the methods and balances right for just her or him. Here lies the opportunity for an individual to come through a dreadful experience and gain from it an even better life balance than prior to the trauma.

In addition to physical fitness, provided by proper nutrition and exercise, developing one's sense of humor, and expanding one's spirituality, there are other approaches worth brief mention.

### *Increase Eustress, Decrease Distress*

There are a variety of ways that a person can maximize positive stressors and minimize distress. Some of these, such as social integration, have already been mentioned. We all need a supportive social network, but victims may find their supports disrupted, at least temporarily. It is still a prevalent response in our culture to blame the victim. In addition, some people will back away out of a desire to avoid facing the terror and horror of the victim's experience. The victim, too, may reduce contacts with people out of fear of continuing traumatization, shame or embarrassment, or emotional constriction. Social integration—both reestablishing old relationships and building new ones—is an important focus of treatment for the victim of violence. Certain skill-building activities may aid the victim, such as communication skills (especially assertiveness and listening skills).



Other sources of eustress may include engaging in satisfying work, cultural and spiritual activities, expressing love, physical exercise, and the process of therapy itself.

The therapist can aid the victim in avoiding distress by helping determine the sources and those which can be either temporarily or permanently avoided. One example worth exploring with many victims is their involvement in criminal justice system proceedings. Some victims will choose, in their own best interests, not to participate, to avoid the many and serious stressors. Others, again in their own best interests, will choose to pursue prosecution of assailants. In this case the therapist's role will be to aid the victim in perceiving these experiences with the criminal justice system in as positive a way as possible.

#### *Attitude Adjustment*

Many distressors are internal and self-imposed in the form of beliefs, values, and expectations. These may be long held or new since the victimization. One example would be a predominant emotional quality of hostility, stemming from a pervasive contempt and distrust of others. Persons with such beliefs are usually moralistic and punitive. They are often found suffering from stress-related problems, such as hypertension and migraines. Certainly, if this is a development since the victimization, the therapeutic task of lessening the intensity of the stressor, or changing these beliefs, will be easier than in the case of lifelong hostility. The best one can do in such a situation may be simply to bring these stressors to the client's attention and aid him in developing some positive perceptions as well.

Epictetus, in the first century A.D., realized that people are disturbed not by things, but by the view they take of them. In working with a client, a therapist must deal first with that person's perceptions of reality, not what the therapist perceives as real. When these appear more negative than necessary, the job is to restructure these cognitions into more positive ones. Although it is simplistic to say that one should see the glass half-full, rather than half-empty, aiding the client in reappraising situations is appropriate. As an example, let us return to the client who has chosen to pursue prosecution of the assailant, and who is experiencing the myriad negative situations so often a part of this process. Helping the victims view these situations as failures of the system, not themselves, and as results of misperceptions of our culture about victimization, will help the clients reduce the negative, distressful impact of these experiences. For those well on their way to



survivor status, it may be possible to perceive these situations as opportunities for educating others. A simple assignment of engaging in positive self-talk a number of times a day can help to counteract situations in which their self-worth is attacked and they are demeaned.

### *Coping Techniques*

Most people never think specifically about the things they do to manage stress. A worthwhile exercise for clients is to develop a written list of specific activities that work for them in producing relaxation and stress reduction. We are reminded at this point of an Ashleigh Brilliant cartoon which reads, "Don't ask me to relax—it's only my tension holding me together." As with most humor, there may be an element of truth here. For highly anxious victims, asking them to relax may be asking them to give up more control than they feel capable of doing, particularly if their symptoms include hypervigilance. Therefore, the possibilities for the list must be drawn from wide-ranging areas and must include stimulation, as well as relaxation.

A good starting point may be to help victims identify what they have done in the past for fun or relaxation. Add to this new possibilities that the therapist may teach, such as guided imagery, meditation, or deep muscle relaxation. Other areas can be added to the list, such as reading humorous or inspirational writings, going for a walk or other exercise, preparing and sharing a meal with a friend or family.

The longer and more varied the list the better. Be sure it is individualized (not just suggestions from the therapist, which may not be right for the client). Collaborate and be creative. Encourage the client to keep the list in a handy place and *use* it on a daily basis.

### *A Sense of Coherence*

Aaron Antonovsky (1979) has studied for many years, in several settings and a variety of populations, people's ability to manage stress and maintain health. Throughout his work he has focused on healthy rather than ill people, and he has attempted to ferret out factors related to this continued health in the face of stressors that result in illness in many. He contends that stressors are ubiquitous and that the source of continued health is the management of stress. He proposes a *sense of coherence* as the unifying concept. By this he means "the extent to which one has a *pervasive, enduring though dynamic* feeling of confidence that one's internal and external environments are *predictable* and that



there is a high probability that things will work out as well as can reasonably be expected" (p. 123, emphasis added). A strong sense of coherence does not necessarily mean a belief that all good things will come easily. A person may view life as complex and full of conflicts, but as essentially comprehensible. Goal achievement may be seen as requiring great effort, and failure and frustration may occur. However, there is a sense of faith that, by and large, things will turn out well.

Antonovsky stresses the importance of distinguishing a strong sense of coherence from an internal locus of control. The crucial issue in the former is not whether one is in control, but rather that legitimate control is where it should be. This may be viewed to be within an individual, within societal authority, or to lie with a deity. A strong sense of coherence is the belief that laws or power, wherever vested, will produce reasonably good outcomes in the long run. The distinction is between one's "being in control over things and things being under control" (p. 155).

A strong sense of coherence is born of and nourished by a host of factors, termed by Antonovsky generalized resistance resources (GRRs). A GRR is any characteristic of an individual, group, or culture that can facilitate effective stress management. Examples range from physical and biochemical GRRs, such as the immune system, through material, cognitive, emotional, and attitudinal GRRs, to interpersonal relational and macrosociocultural GRRs, which provide us our place in the world through rituals, mythology, art, and social structure. The foundation of an individual's sense of coherence is believed to be laid down within the basic personality structure of the developing child and is strengthened or weakened through succeeding experiences throughout life.

Since there is a large element of comprehensibility, predictability, and lawfulness in a strong sense of coherence, capricious and arbitrary events may weaken one's sense of coherence. This is more likely if the person's feeling of confidence is more of an intellectual and cognitive belief, rather than faith, as in the sense of a belief without proof. This is a spiritual, perhaps religious, concept, and a truly strong sense of coherence does not dissipate unless faith is lost. Victimization may certainly test the limits of faith, and such an experience can at least temporarily weaken one's sense of coherence. To the extent that a therapist's behavior can help strengthen it again, a victim's overall coping ability and health status are likely to benefit.

The therapist, as a potential GRR, has the opportunity to structure her or his interactions with the client so as to reinforce their sense of



coherence, however weakened it may be following the victimization. Indeed, we see the therapist as having a significant role to play in the difficult, slow, and possibly painful task of rebuilding the strength of the sense of coherence to pre-trauma levels. Educating victims about post-traumatic stress will reestablish predictability and understanding of their experiences. Shared decision making with the therapist will give the message that "things are under control." Aiding victims in reawakening their spirituality will rekindle the faith implicit in the sense of coherence.

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## *Post-Traumatic Family Therapy*

CHARLES R. FIGLEY

This chapter describes a family-centered treatment program. It is based on the assumptions that each person experiencing traumatic stress must be viewed within a social network of supporters, including family members, and that by focusing attention on this system of social support, individual and systemic symptoms of post-traumatic disorder become evident. Much of the chapter describes an approach to treatment of the families of "victims" of traumatic stress. The approach first carefully specifies the goals and objectives of treatment, the preconditions prior to treatment, assessment/diagnosis. The treatment program involves five integrated phases. Each is described in detail and implications for treatment and research are discussed.

A case of post-traumatic stress disorder (PTSD) was recently presented in a well-known psychiatric clinic by a top psychotherapy intern. The client, John Burns (not his real name), sought treatment for exhaustion, though by all indications John is a model of a happy and productive executive. But in the last six weeks his life has been in shambles. He is able to sleep only a few hours each night. He has missed more work than ever this past month owing to various minor illnesses than at any time in his life. He feels jumpy, irritable, and fluctuates between apathy and rage. According to his wife of 10 years, he no longer is interested

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I am grateful for the important comments provided by the editor of this volume and by my students, particularly Cassandra Erickson, C. J. Harris, and Shirley Ann Segal.



in the things that once brought him joy: his children, Little League coaching, fishing, photography.

What is most troubling to John, however, is his reexperiencing several troubling memories of past events. These events occurred over 15 years ago when he was a corpsman in Vietnam. Though never thinking about the war much, he now experiences both daydreams and nightmares of the war almost daily. He has tried to talk about it with his wife. She has listened and has tried to encourage John to put his memories behind him for the good of his family and himself. He tries to forget the past, but is unable to. Moreover, he is unable to recall certain periods of time during his year-long tour of duty in the war. He is frightened, confused, and concerned that his boss and co-workers will think he is unable to function effectively in his extremely responsible position.

To John and his family it is hard to understand how and why events of the distant past could be responsible for much of his current difficulties. Other chapters in this volume focus on effective diagnosis and treatment of the symptoms exhibited by John. In this chapter John's problems are important, but only as a part of the more complex problem of John's family resulting, in part, from the difficulties John is having with traumatic stress (Figley, 1985a).

Following the presentation of John Burns' case, the director of the mental health clinic asked the presenting intern about John's family: how they are coping, both as a family and as a set of individuals, with John's traumatic stress reactions. It became clear that the intern had not fully assessed the family system, but would do so immediately. Some weeks later the intern reported that the family is in chaos. The wife has threatened divorce, is frequently depressed, has difficulty sleeping, and may be abusing alcohol. The two children, a daughter, 11, and a son, 9, are also very upset about their father and mother's recent behavior. Both children are doing poorly in school, tend to avoid being at home with their father, and fight among themselves more frequently. The daughter has contemplated suicide more than once in the last month.

Most of these problems are directly related to John's problems. They began after John began to recall his experiences in Vietnam and the subsequent emotional impact they had on this behavior.

A contemporary, well-trained clinician would probably recognize that Mr. Burns is suffering from, among other things, a post-traumatic stress disorder (PTSD). PTSD is an anxiety disorder directly resulting from a catastrophic event (American Psychiatric Association, 1987, pp. 247-251).



His symptoms are not unlike those of other clients presented throughout this volume. Indeed, this chapter builds on the work of others in this volume.

The focus here is not on the individual victim's struggle to recover from the victimization experience. This chapter focuses on both the significance of the family in the struggle of victims to recover and, more important, the simultaneous struggles of the family and its members and specific methods to facilitate recovery as a family.

## PURPOSE AND OBJECTIVES

Thus, the purpose of this chapter is to present a rationale and approach to family therapy with the traumatized client and the client's family. Specifically, the chapter will (1) review the literature on the significance of the family to victim recovery; (2) discuss the use of family therapy in treating traumatized clients; (3) describe an approach to assessment of traumatized families; (4) outline an approach to family therapy with these families; and (5) discuss the implications for post-traumatic family therapy for research and treatment innovation.

Here I shall focus on the family traumatized by forces outside its system boundaries and how the family can mobilize its natural resources to recover, with or without professional intervention. Elsewhere I shall discuss the special circumstances of the family traumatized by forces *within* its systemic boundaries (Figley, 1988). These self-destructive families are especially vulnerable to destruction and often require considerable professional assistance to recover.

As noted elsewhere (Figley, 1985b), I define catastrophes and traumatic events as "an extraordinary event or series of events which is sudden, overwhelming, and often dangerous, either to one's self or significant other(s)" (p. xviii). Trauma is defined as "an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shattered the survivor's sense of invulnerability to harm" (p. xviii). Traumatic stress reaction is defined as "a set of conscious and unconscious actions and emotions associated with dealing with the stressors of the catastrophe and the period immediately afterwards" (p. xix). Post-traumatic stress reaction is defined as "a set of conscious and unconscious behaviors and emotions associated with dealing with the memories of the stressors of the catastrophe and immediately afterwards" (p. xix). Finally, post-traumatic stress disorder is defined as:



An anxiety disorder produced by an uncommon, extremely stressful event (e.g., assault, rape, military combat, flood, earthquake, death camp, torture, car accident, head trauma), and characterized by (a) reexperiencing the trauma in painful recollections or recurrent dreams or nightmares, (b) diminished responsiveness (emotional amnesia or numbing), with disinterest in significant activities and with feelings of detachment and estrangement from others, and (c) such symptoms as exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, guilt about surviving when others did not, and avoidance of activities that call the traumatic event to mind. (Goldenson, 1984, p. 573)

The introduction to this volume describes the difference between victimization and traumatization. The former involves subjugation, shame, and self-blame, in contrast to the latter, which is associated more with fear, shock, and arousal. As I have noted elsewhere (Figley, 1985a), a trauma victim is a person who, in the process of recovering and working through the traumatic experiences struggles to make sense out of the memories of the traumatic event. Recovery is to eventually accept them and be able to face the possibility that something else like it may happen again. A trauma survivor is one who has successfully worked through and made peace with his or her traumatic memories.

### FAMILY AS A SYSTEM OF SOCIAL SUPPORT

Elsewhere I have discussed the importance of the healthy family system in the process of recovery for individuals suffering from traumatic and post-traumatic stress disorder (Figley, 1983, 1985a, 1985b, 1985c, 1986a, 1986b; Figley & Sprenkle, 1978; Hogancamp & Figley, 1983; Stanton & Figley, 1978). As an intimate social support system, family members promote recovery in at least four separate and related ways: (1) detecting traumatic stress; (2) confronting the trauma; (3) urging recapitulation of the catastrophe; and (4) facilitating resolution of the trauma-inducing conflicts.

#### Detecting Traumatic Stress

The concept of the family is derived from the Latin term *familia*, which means "household" and includes everyone who lives there (e.g., family members, housekeeper, boarders, live-in relatives, friends). Anyone bound by a household—be they tied by blood or law—becomes



well aware of the habits, dispositions, and patterns of behavior of fellow inhabitants. Add to this the similarities of inherited and acquired traits of family members, and what emerges in most families is a remarkable "feel" for the normative behavior of fellow family members.

Thus, in a "healthy" family, when one family member is having a "bad" day, others know it immediately. When a family member has experienced a catastrophe, he or she is "expected" to behave differently. Even when a family member displays symptoms of post-traumatic stress disorder for which the cause may be unknown, other family members detect the changed pattern of behavior almost immediately.

### *Confronting the Trauma*

Once the traumatic or post-traumatic stress reactions are noticed, family members are also in a position to help the victim. This may be done by simply linking the victim's behavior to the traumatic event. The method of confrontation is most often tailored to the individual needs and style of the victim in a way that only another family member could understand. For some, the direct approach is used. For others, a more subtle method of confronting the victim has proven more effective over the years.

In the case of Mr. Burns, for example, Mrs. Burns left him a copy of a book about the readjustment problems of Vietnam veterans following a week of nightmares about the war. He had responded favorably in the past to receiving from her various books and articles about issues and problems he was facing at the time.

### *Urging Recapitulation of the Catastrophe*

A third way that families provide social support and facilitate recovery from trauma is by *assisting the traumatized member to reconsider the traumatic events: to recapitulate what happened*. This issue is very important to the recovery process. As Figley has noted (1985a, 1986a, 1986b), those struggling to recover from traumatic events attempt to resolve four fundamental questions: What happened? Why did it happen? Why did I and others act as we did, then and since then? And, if something like this happens again, will I be able to cope more effectively?

In the process of recapitulation, the family member enables the victim to recall facets of the trauma that are critical in answering the other victim questions noted earlier.



*Facilitating Resolution of the Conflicts*

Finally, the family can be extremely useful in helping the victim work through his/her traumatic memories and accompanying conflicts by reframing the traumatic events and developing a "healing theory" (Figley, 1979). All of the victim questions must be answered to the satisfaction of the victim. Most important, the family member serves as an effective facilitator in developing a healing theory. This requires considerable knowledge about the victimized family member that is well-known to fellow family members, but is acquired very slowly by therapists and others attempting to assist the victim. Family members, for example, may choose to be either active or passive, use mutual self-disclosure or not, be confrontative or not.

Another method of facilitating resolution of the traumatic event for fellow family members is by serving as a sounding board, very much as therapists are trained to work with clients. This includes: (1) clarifying insights, (2) correcting distortions (placing blame and credit more objectively), and (3) offering or supporting new and more "generous" or accurate perspectives on the catastrophe.

## THE COST OF CARING

As noted elsewhere (Burgess & Holmstrom, 1979; Figley, 1982, 1983, 1985a, 1986a, 1986b; Kishur & Figley, 1986), there are costs to providing social support, particularly for close family members. Indeed, as catastrophes affect individuals, so do they affect the families of these victims: these families should be viewed as the "families of catastrophe."

In addition to being directly affected by catastrophes as individuals, persons belonging to families with a victimized member experience traumatic stress (Figley, 1983; Kishur & Figley, 1986). They are traumatized in at least four separate ways: (1) *simultaneous effects*, as when catastrophe directly strikes the entire family (e.g., fire, natural disaster, auto accident); (2) *vicarious effects*, as when a catastrophe strikes one family member, but the family is unable to make direct contact with the victimized member (e.g., war, coal mine accident); (3) *chiasmal effects*, as when the traumatic stress appears to "infect" all family members after making contact with the victimized family member; and (4) *intrafamilial trauma*, as when a catastrophe strikes from within the family (e.g., incest, violence, divorce).



### *Simultaneous Effects*

Perhaps one of the reasons natural disasters appear to leave so few emotional scars (cf. Quarantelli, 1985) is that they often strike intact social support systems simultaneously: families, neighborhoods, communities. Conversely, this widespread destruction is linked with considerable social and emotional disruption (Gleser, Green, & Winget, 1981). As a result *everyone* is a fellow survivor and is able to appreciate and provide effective and knowledgeable support. There is little "blaming the victim," for example, because *everyone in the family* is a victim. Families affected simultaneously by disaster are able to help each other to overcome the emotional horrors, rebuild, and recognize any valuable lessons that can be learned. Catastrophe-related pathology is rare in these situations.

### *Vicarious Effects*

The emotional attachments to others through familial and friendship bonds enable us to feel safe, secure, loved (cf. Figley, 1973; McCubbin & Figley, 1983a). When we learn by some medium (e.g., telephone, television, letter) that a catastrophe has affected someone we love, it is extremely stressful (Figley, 1983). The recent experience of a large group of Americans held hostage in Iran provides an illustration of this phenomenon (Figley, 1980; McCubbin & Figley, 1983b): the families experienced more stress while at home than many of the hostages in captivity. For example, while the daily routine of the hostages was highly regimented and predictable, with little access to new information, their families were constantly bombarded with new information about the captivity experience (most often false rumors) and the family routine constantly changed. Frequently, hostage families were forced to respond to a wide variety of new situations they neither welcomed nor were prepared to deal with.

### *Chiasmal Effects: "Infecting" the Family with Trauma*

In the process of attending to the victimization of a family member, supportive family members themselves are touched emotionally, though indirectly. They are affected directly by the reactions of the victimized family member, of course. In an effort to help, supportive family members begin to experience the impact of the catastrophe directly. Figley (1983) has described this phenomenon as secondary catastrophic



stress response. Others have used other terms to describe this and similar responses.

A recent study reported by Kishur and Figley (1986) has presented evidence of this phenomenon long observed in the clinical literature. They describe the phenomenon of the "transmission" of behaviors in general, and emotional experiences in particular, as the *chiasmal effects of traumatic stressors*. Specifically, they define it as "the phenomenon of behaviors, impressions, actions, attitudes, or emotions which are first seen in one person following an emotionally traumatic event and subsequently observed in a support at a later time" (p. 3).

In their study of crime victims and their supporters—especially family members—Kishur & Figley (1986) note that

as expected, the major predictor of *supporter distress was victim distress* [and that] it is clear that a pattern of effects emerged in both the victim and supporter. The crime victims as well as their supporters suffered from the crime episode long after the initial crisis had passed. Symptoms of depression, social isolation, disruptions of daily routine, and suspicious feelings of persecution affected the lives of these persons. (p. 18)

Thus, in the process of abating traumatic and post-traumatic stress reactions, supporters are quite susceptible to being traumatized themselves. It is especially important, therefore, that each person who appears to be suffering from post-traumatic stress disorder be viewed within a family context of those victimized indirectly as a result of their concern for the victim.

It is important to answer the following questions: What is the extent to which this family is providing social support to this client? What is the extent to which this family is functioning (i.e., balance between cohesion, adaptability, and interpersonal/family skill level)? And to what extent are any other family members suffering from mental disorders (e.g., PTSD)?

## FAMILY THERAPY WITH TRAUMATIZED FAMILIES

### Background

Although considerable research and writing exists on the assessment and treatment of PTSD of victims of various types of catastrophes (cf.



Figley, 1985a), relatively little attention is given to social relationships. Among the first efforts to recognize the role of social relationships was the classic study of families of World War II veterans, by Rueben Hill (1949). Hill, to most observers, originated the concept of family stress. He was the first to suggest that the system of the family is greatly affected by crisis events, such as war and postwar reunion. This sociological orientation emerged into what was later to be called the ABCX model of family crisis (Hill, 1949; Hill & Hansen, 1965) and has evolved into the current double ABCX model (McCubbin et al., 1980) and subsequent models (cf. McCubbin & Patterson, 1983).

McCubbin and his associates suggest that the extent to which the family experiences and resolves a crisis (invoked by either normative, nonnormative, or catastrophic events) is a function of the nature of the event, the family's definition of the event, the family's resources, the buildup of stressors, and the effectiveness of past and current coping efforts. Croog (1970) and others (e.g., Figley, 1979) have noted that, by their very nature, families are stress-producing systems. However, there is considerable variation in the extent to which families cope with stress generated from either inside or outside its system.

Montgomery (1982), in addition to providing a family psychological perspective of family crisis and stress, suggests that these families must "maintain a balance between integration (keeping the family together) and instrumentality (getting things done or dealing with the stress)" (p. 33). Moreover, he contends that families must balance consistency (being predictable in their actions) with flexibility (enabling the family to change existing patterns whenever they contribute to the family's stress). The family's capability of dealing with stress depends on the effectiveness of both its execution (task completion) and correction (decision-making) patterns. Montgomery also suggests that capability can be enhanced by family value congruency and value-behavior agreement on the part of family members.

Although the sociological and psychological explanations are helpful in understanding and appreciating families under extraordinary stress and crisis, neither provides clear-cut guidance in helping families recover, particularly from traumatic events and circumstances.

Family therapy is an appropriate method for resolving trauma-related adjustment problems. In my work with Vietnam veterans more than a decade ago (Figley, 1976a, 1976b), I found that those individuals most traumatized by their experiences are the ones most impaired interpersonally; that traumatic residue eventually becomes enmeshed in the victim's interpersonal network; and that there is a clear need of marriage



and family therapy to both improve the support of this network and promote recovery of the network (family) itself.

My colleague, Duncan Stanton, and I (1978) were among the early investigators who developed the method of intervention in family systems suffering from post-traumatic stress disorder (PTSD). We indicated that the therapist has two major and overlapping tasks: (1) to assess the degree of severity of the member's disorder, particularly how the family tends to modulate it through its specific relationship dysfunctions, and (2) to develop and implement an intervention program to deal with both the stress disorder and the associated dysfunctions within the system. Drawing on systems, family stress, and family therapy theories, some authors (e.g., Haley, 1971, 1976; Minuchin, 1974) present a brief outline of therapy divided between approaches with the family of origin (drawing especially from Stanton et al., 1982) and those with the family of procreation (drawing especially from Haley, 1976). Though basic principles were presented here and elsewhere (cf. Figley & McCubbin, 1983; Figley, 1986a, 1986b), few specific procedures were described in detail.

### *Theoretical Orientation*

Systems theory has emerged as the primary theoretical orientation for family therapists worldwide. By viewing the family as a system and individual members and their various dyadic and triadic relationships within the family as subsystems, psychotherapists develop intervention programs to ameliorate various presenting problems: both individual and family. Among the most empirically grounded systems approaches is the circumplex model of marital family systems. It is designed to both generate information about particular families and organize that information into relevant treatment goals (Olson, Sprenkle, & Russell, 1979).

Olson and his associates, after a thorough analysis of the family process literature, observed that two themes emerged. One involves reconciling the simultaneous and contradictory push toward both separateness and togetherness within the family system. They call this the *cohesion dimension* and define it as the emotional bonding members have with one another and the degree of individual autonomy persons experience in the family system. Extremes of family cohesion are described as "enmeshment" and indicate a paucity of individual autonomy—through an apparent surplus of family interdependency, which is highly valued in some families and cultures. "Disengagement," on



the other hand, is characterized by low bonding among family members and indicates high individual autonomy, which is highly valued in many American families, especially among teenagers.

Families attempting to cope with an extraordinarily stressful event, for example, tend to want to draw together for mutual comfort and emotional assistance. Yet, at the same time, because family interaction under stressful conditions often increases stress, there is also a tendency to separate, to avoid interaction, particularly discussions of the trauma.

Theoretically, the most crisis-resistant families are those that are "balanced" in terms of the family cohesion continuum. They foster intimacy, yet are neither overly "connected" nor overly "separated."

Olson et al. (1979) call the second theme the *adaptability dimension*. It involves the ability of the relationship system to respond to developmental or situational stress with appropriate shifts in the power structure, relationship roles, and rules. Specifically, they view family adaptability as the ability of a relationship system to change its power structure, role relationships, and relationship rules in response to a situational or developmental stressor. As with the cohesion dimension, there are extremes in family adaptability. These are described as either "chaotic" (too high) or "rigid" (too low), in contrast with the more balanced family adaptability styles: called "structured" or "flexible."

Families in crisis, such as the Burns family, frequently must not only cope with the fear of one of its members being incapacitated, they must also contend with its consequences: major disruptions in their life-style and routine. These families, after some attempts to help the affected family member, may eventually focus on their own individual losses to the detriment of the victim. Applying the circumplex model and utilizing a battery of associated psychometric tests, the Burns family could be described as chaotically separated in that they are low in cohesion and high (too high) in adaptability.

Both these dimensions are a description—rather than an evaluation—of family dynamics. Ideally, the family must balance both cohesion and adaptability for optimum family functioning at all times, but especially in times of stress. This is because these times, of course, require optimum family functioning, including creativity, conflict resolution, problem solving, resource management.

A detailed description of the circumplex model is available elsewhere (Olson, 1985; Olson, Lavee, & McCubbin, 1986; Olson et al., 1979; Olson, Russell, & Sprenkle, 1983; Sprenkle & Olson, 1978). This model provides an effective method of assessing families (a measure called FACES) on these dimensions (Olson, Portner, & Lavee, 1985) for both



treatment planning and treatment outcome evaluation. For example, those assessed with scores that are either extremely high or low in either cohesion or adaptability would be judged as being vulnerable to a crisis situation. If these types of families are currently in treatment, major changes in their lives which would generate additional stressors (e.g., changing residence) would be discouraged.

Similarly, successfully treated families should have more balanced scores than when they sought treatment, and efforts to help families "balance their family relationships" would be part of the treatment plan. This will be discussed later within the context of the phases of treating family traumatic stress.

### *Family Relations Skills*

A major element of treating families, particularly families in crisis, is focusing on the development of a variety of interpersonal relationship skills. These include behaviors that appear to lead to effective and efficient (1) exchange of information between family members, (2) problem solving, and (3) conflict resolution.

By fostering family relations skills family members are able to fully exploit their own individual resources and those of other family members in helping to seek and resolve the current crisis. There are a wide variety of models for teaching these skills to people within a family context. An excellent example is Bernard Guerney's (1978) relationship enhancement (RE) program. This approach will be described later.

### *Family Social Supportiveness*

By focusing on the competing dynamics within the family of cohesion and adaptation and fostering effective family relations skills, families will become more effective as a medium for providing social support. Social supportiveness has been found to promote, among other things, individual coping with stress (cf., Pilisuk & Parks, 1986).

### *Purpose of Family Traumatic Therapy*

The purpose of this approach to family treatment is to facilitate normal family functioning, including, but not limited to, social support effectiveness (to the extent that levels of social support are perceived to be satisfactory): in other words, to enable the family to function as they would have done were it not for these circumstances. In the



process the self-esteem of the family in general and the esteem of the members of the family in particular will be raised at least to levels prior to the impact of the traumatic event.

## TREATMENT PRECONDITIONS

It is important, prior to therapy, to establish the ideal preconditions for effective therapy. It is important, for example, to determine: (1) What set of circumstances brought this family to treatment? (2) How committed are they as a family? (3) Is there an accurate PTSD diagnosis of a member? (4) What is the extent to which family members are suffering? Finally, (5) a method of family relations skills training must be established.

### *Special Circumstances of Families*

It is important to recognize that traumatized families can be classified into two categories of clients for post-traumatic family therapy: those suffering from *internal* traumatization and those suffering from *external* traumatization. As noted earlier, the focus of this chapter is on the latter, help-seeking families. Elsewhere in this volume my colleagues discuss methods of helping families victimized by intrafamilial abuse.

It is important to recognize that the former type of family will require much more time and skill to treat. They have been traumatized from within the boundaries of the family system most often by one or more family members. Family member violence and abuse against one another are prime examples of this type of victimization. The extent of victimization is typically system-wide, affecting all family members to varying degrees. Most frequently these families have been exposed to this abusive environment for extended periods of time and often have developed specific methods of coping with the stress and the problems that produce the stress. In addition to the direct effects of abuse of its members, these families suffer from limited and sporadic social support due to the extent of individual impairment and the lack of trust.

It is encouraging to see that the clinical and scholarly literature focusing on these internally traumatized families is growing. Indeed, several new journals have been established recently to further promote and develop this field. Moreover, hundreds of treatment and prevention programs have been established worldwide to help families affected by or vulnerable to intrafamilial abuse.



In contrast, however, little clinical and scholarly attention is given to the family traumatized *outside* its system. Most of the attention is paid to the victimized or traumatized family member. The rest of the family, when considered at all, is viewed as a group who must be informed in order to focus attention on the problems and needs of the victimized member. Families who seek assistance need to be oriented to view the victimization as a *family problem*, not just a problem of the victimized member.

### TREATMENT OBJECTIVES

1. *Building rapport and trust and clarifying the therapist's role.* Developing a therapeutic alliance with the family is idiosyncratic in any effective clinical intervention. Therefore, each psychotherapist must utilize his or her own methods. Since the method of treatment that is explicated here is one of empowerment, however, it should be pointed out to the clients that (1) in most cases the actual therapy will be relatively brief, (2) the role of the therapist is to *facilitate* recovery and self-reliance, (3) the task of the family is to refine and develop their own skills for coping with extraordinary circumstances, (4) success will not only improve current circumstances, but enable the family to cope more successfully with future ordeals, and (5) they can—individually and as a family—be useful to others attempting to cope with similar circumstances.

Beyond testimonials and reassuring statements of purpose, however, the therapist must *demonstrate* the utility of this approach in order to develop sufficient trust of all family members. This can be done in the initial or subsequent sessions using the technique of roundtable testimonials, which will be discussed shortly.

2. *Developing new rules and skills of family communication.* Typically in families, unwritten rules emerge over years of interaction which prescribe the manner and content of communication among family members, depending on the context (i.e., public versus private versus semiprivate) (cf. Watzlawick, Beavin, & Jackson, 1967). Family rituals and secrets stylize and rigidify family interaction, resulting in a pattern of family behaviors that are generally functional in day-to-day activities and less functional during extraordinary times, such as holidays, vacations, and other nonnormal periods. Thus, family interaction patterns



are often dysfunctional during periods of high stress and crisis, such as in the wake of a traumatic event that impairs one or more family members.

Family members should be aware that the purpose of therapy is to facilitate effective coping with these extraordinary events, those in which the family has very little experience. Family members must become convinced that to do this—to cope with extraordinary circumstances—requires extraordinary methods (rules and communication skills) which they can, if they wish, view as temporary until the problem is solved.

New family rules and communication skills include those which encourage the free exchange of ideas in a clear and efficient manner. A portion of the family therapy sessions and subsequent homework should involve teaching these new interaction methods. Several approaches have proven effective with families (cf. Guerney, 1978; Miller, Nunnally, & Wackman, 1975).

3. *Promoting self-disclosure.* With new rules and skills for encouraging self-disclosures among all family members, therapists should reserve sufficient time to ensure that all family members talk about their feelings. As a result both the rules and skills are reinforced and, more important, the hidden insights, feelings, and fears of all family members are more likely to be exposed and dealt with effectively.

4. *Recapitulation of the traumatic events.* More specifically, therapists should encourage each family member to articulate his or her experiences and feelings associated with the traumatic event in as much detail as possible. For example, talking about what kind of day it was when they first learned of the event, what they were wearing, what they did and felt during and after learning of the event. This will trigger new information, insights, and conclusions associated with the event. For the entire family—as well as the identified victim—this will reinforce the idea that the entire family was affected by the event and how important the identified victim is to everyone.

As the individual family member stories are told—about how each experienced the traumatic event and its wake—a picture of the family trauma will emerge, for example, that all were quite upset and worried and tried to cope in their own ways. These coping attempts helped or did not help. And at times these efforts did more harm than good, compounding the stress for the traumatized person as well as other family members.



By the entire family listening to the individual stories of each family member, new insights emerge which lead to important alterations in the perception of the situation. Specifically, the family begins to develop a consensus view which can answer the fundamental victim questions: what happened, why it happened, how each person reacted initially and subsequently. These perceptions inevitably lead to greater acceptance as well as understanding of past and present behavior and attitudes of fellow family members.

For example, as the Burns family began to identify the initial period of their efforts to help Mr. Burns, daughter Sandra recalled how worried she was about her father. In an effort to "get his mind off of Vietnam" one Sunday, she decided to insist that he take her to a movie. However, because of her insistence, she was accused by him of being "a spoiled brat."

5. *Building a family healing theory.* I (Figley, 1979, 1983) have adopted Horowitz's (1976, 1986) thesis that the traumatized work through their experiences by developing new realities about the causes and circumstances of the traumatic event. I have called this new thesis a person's "healing theory," since it is a perspective that fully accounts for what happened and why each person acted as he did.

A critical objective in this approach is to help all family members articulate their own, individual healing theory and then, beginning from the collection of family member stories and theories, to help the family build a family healing theory.

It is critical that the therapist allow the family to struggle with the various views of the trauma and its wake and the collective meanings of family members. Eventually, the therapist should be able to help the family develop a single, unifying healing theory, reframing statements to fit a pervasive family healing theory.

A family healing theory, then, is a set of statements about the circumstances under which the traumatic event happened, how and why each family member behaved as he did (during and following the event), and an optimistic scenario of what would happen if a similar traumatic event took place again. Although it is not expected that every family member will embrace this consensus view (family healing theory) with equal enthusiasm, at least every family member will recognize the need for such a view and be willing to support it for the common welfare of the family. To achieve this consensus, then, the family healing theory may need to be rather general and avoid language that is controversial.



## FAMILY ASSESSMENT

*Clinical Interview*

During the initial/intake interview with the family and, perhaps, one or more subsequent sessions, it is important to assess the extent to which the family has coped with the traumatic event. I have found from my work and the work of others (cf. McCubbin & Figley, 1983b) that there are 11 criteria that distinguish functional versus dysfunctional family coping. Table 1 lists these parameters. Some questions useful in making this determination are: Does the family have a clear understanding and acceptance of the sources of stress affecting them? Do they see the difficulties they face as family-centered or do they blame one or two family members? Do they appear to be problem solution-oriented or blame-oriented? What are the general levels of tolerance for one another? How committed are the family members to one another? How much affection is there in this family? What are the quality and quantity of communication among members in this family? How cohesive are they as a group? How flexible are the family roles? Do they tend to utilize or avoid resources outside the family? Do they serve as a resource to others as well? Is there evidence of family violence? Is there evidence of drug abuse? A more standardized protocol for collecting additional important clinical information is available also (see Clinical Rating Scale by Olson & Killorin, 1985).

TABLE 1\*  
Contrast Between Functional and Dysfunctional Family Coping

Characteristics	For Families that are coping	
	Functionally	Dysfunctionally
Identification of the stressor	Clear, Acceptance	Unclear, Denial
Locus of the problem	Family-centered	Individual-centered
Approach to the problem	Solution-oriented	Blame-oriented
Tolerance of others	High	Low
Commitment to and affection for family members	Clear, Direct	Unclear, Indirect
Communication utilization	Open	Closed
Family cohesion	High	Low
Family roles	Flexible, Shifting	Rigid
Resource utilization	Balanced to High	Low to None
Use of violence	Absent	Present
Use of drugs	Infrequent	Frequent

\* From McCubbin and Figley (1983b). Reprinted with permission.



### *Estimates of Social Support Satisfaction*

Since the major focus of this therapy is to develop social support satisfaction among family members, it is critical to estimate, as early as possible the degree of satisfaction prior to treatment. One method found to be highly valid and reliable is the Purdue Social Support Scale (Burge & Figley, 1987). In a brief, simple-to-administer questionnaire, respondents are first asked to list those they "turn to in times of need." Next they are asked to estimate their satisfaction when and if they were to turn to each of these persons with regard to overall helpfulness and five other indicators of support: tangible aid, companionship, advice, encouragement, and emotional support. Support satisfaction scores can then be computed for each supporter listed as well as for each dimension of support and overall helpfulness.

### *Estimates of Adaptability/Cohesion*

Based on the circumplex model of family systems, "balanced" families, those that avoid the extremes of high or low cohesion or high or low flexibility (adaptability), have been found to be the most "healthy" and fully functioning in a wide variety of settings (cf. Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1983). It is reasonable to expect that these families are in a better position to administer social support and reach a mutually satisfying healing theory. It is important to identify the type of family vis-à-vis this categorization prior to treatment. FACES (Olson et al., 1985) was developed specifically for this purpose.

### *Family Relations Skills*

As a method of enabling family members to become more supportive to one another, particularly the primary victim, and to reach consensus healing theory, family relationship skills are taught in this program. One of the most frequently used instruments in assessing pre-post training in this area is the Marital Communication Inventory (MCI) (Bienvenu, 1970). The MCI was developed to provide estimates of the quality and quantity of marital communication. Guernsey's (1977, p. 344) Family Life Questionnaire (FLQ) was developed to measure harmony and satisfaction in family life from the point of view of each member. In addition to measuring the quantity and quality of family communication, this measure assesses a number of other dimensions of family



skills functioning, including, for example, empathic responding, speaker selectivity, and communication role switching.

## FOUR TREATMENT PHASES

### *Phase I: Building Commitment to the Therapeutic Objectives*

Commitment and trust are critical elements in psychotherapy treatment methods. The early phase of intervention is primarily dedicated to this end. It is important, especially in the beginning, to convey respect for the client family and an appreciation for their suffering. Getting the family—as many members as possible—to disclose their ordeal, I have found, develops and promotes commitment to the treatment program. Other critical factors at this phase include: (1) articulating the major sources of stress endured by the family, (2) identifying the specific treatment objectives, (3) noting the high degree of optimism for a positive treatment outcome, and (4) conveying a sense of confidence, authority, and experience as a therapist who has dealt with other, equally difficult cases.

### *Phase II: Framing the Problem*

After building commitment to the treatment objectives, it is important to allow the family members to disclose how they view the problem. This phase of therapy involves collecting detailed information about reactions to the traumatic event. Among other things, the therapist should: (1) allow all family members to articulate their own views and reactions relevant to the traumatic event, (2) promote understanding and acceptance of these realities among all family members, (3) help the family list wanted as well as unwanted consequences of the traumatic event, (4) encourage disclosure about the purpose and utility of the current psychotherapy, and, in the process, (5) promote new rules that permit and encourage self-disclosure among all members during the session, and (6) shift attention away from the "victim" and toward the family system that has been victimized.

*Roundtable testimonial.* Early in the treatment the family is encouraged to begin to reframe the consequences of the traumatic event. The therapist's task is to praise any attempts by family members to shift attention AWAY from viewing only one victim in the family to viewing



the entire family as being victimized. Family members should be encouraged (but not lectured) to view the traumatic event that has disrupted family routine; to recognize that they have been deprived of the benefits of a normal family life owing to the events and circumstances surrounding the trauma; and to understand that they as a family must rally together to help each other overcome this tragedy.

In an effort to identify the full extent of the consequences of the traumatic event, I encourage each family member to talk briefly (five to eight minutes) about what the traumatic event *means to him or her as a person and how his or her life has been disrupted*. By assuring that these testimonials will be given and received—rather than allowing them to lapse into a blaming session—the experience has been quite productive. For example, the nine-year-old boy of the Burns family disclosed that: "I can't talk about my baseball game because Daddy keeps talking about the war."

The therapist asked at this point, "And how did that make you feel?" This helped the son identify the feelings he had related to these circumstances, and he went on to admit that his father's attention was important to him, but he understood that it takes time to feel better about something that was real scary.

*Blaming the victim.* Frequently there is considerable animosity among family members toward the "victim." He or she is viewed, for example, as weak, unintelligent, incompetent, or unlucky. One of the goals of therapy is to enable family members to purge these feelings and, in the end, implicitly or explicitly communicate forgiveness of the "victim." By doing so, responsibility for the current situation shifts to individual family members, who become more responsible for their fate.

### Phase III: Reframing the Problem

This phase is the most critical. Here the therapist must help the family generate and assemble the various feelings and perceptions associated with the traumatic event. Eventually, the therapist must help the family develop a healing theory about the event and possible future events. To do this the therapist must help the family reframe the various family member experiences and insights to make them compatible in the process of constructing their healing theory. In the Burns family, for example, Mr. Burns revealed that his wife began to avoid talking with him more and more, by going to bed and getting up before him. He believed that this was an indication of her not wanting him to talk



about his painful war experiences. He slowly began to see that there was another explanation. She felt like a failure as a wife because she was unable to help him work through his trauma. Each time he brought it up or displayed symptoms of PTSD, it was a reminder of her failure. He began to reframe his perception of her behavior from a sign of rejection to a sign of love.

Eventually, the entire family began to recognize that what they once saw as a tragedy and a terrible burden was now a challenge and that they could work together to overcome this problem. They began to realize that working through this crisis together made them better equipped as a family to deal with future adversities.

#### *Phase IV: Developing a Healing Theory*

The final process of recovery from trauma is developing a healing theory. As noted earlier, a family healing theory is a set of statements about the circumstances under which the traumatic event happened, how and why each family member behaved as he did (during and following the event), and an optimistic scenario of what would happen if a similar traumatic event took place again.

Unlike individual treatment, in which the therapist guides the development of a single healing theory, families must develop one that all its members embrace. This is no easy task, especially in chaotic families (those with little cohesion). Therapists should take note of statements clients make during the sessions which are candidates for inclusion in the healing theory. They include those which (1) address one or more victim questions, (2) are endorsed by everyone, (3) are generally supportive, and (4) focus on the victimized family more than on a victimized family member. As each family member shows signs of insight and acceptance of the current crisis and optimism about handling this and future challenges, the therapist begins to guide the family to articulate the full meaning of the trauma and its wake. This is done by asking each family member to address each of the victim questions: What happened? Why did it happen? Why did I, myself, act as I did throughout this ordeal? If something equally as challenging happens in the future, will I cope better?

As each family member summarizes the situation, other family members frequently ask for clarification or justification. In the end, the family settles on a consensus view or healing theory about the traumatic event and its impact on the family. In the case of the Burns family, this healing theory emerged as the consensus view of all its members:



We love Dad very much and his becoming upset about the war made us realize how important he is to all of us: as father, husband, and friend. At first he seemed angry and depressed and we blamed ourselves. We thought he was mad at us, wanted us to go away. We were afraid he was trying to tell us that he wanted to move out. Now we know that the memories of the war and his experiences as a corpsman had always bothered him and that only now was he ready to finally deal with them. It took him—and us—a while to figure out what was happening. We tried, in our own ways, to help. Most of the time we did not help because something like this has never happened before. We now see that these attempts, though unsuccessful, were signs of love and caring. We now see that Dad was bothered by the war because he is a kind and sensitive man who endured a very scary and depressing time. He now understands why he has acted as he has since the war and knows what to do if he has bad feelings about the war again. We have grown closer as a family because of this situation. We are stronger and tougher than ever and can deal with any other problems that might happen in the future and be helpful to other families who might become overwhelmed as we were. We are survivors!

As noted earlier, it is not necessary for all members of the family to adopt the family theory with equal amounts of enthusiasm. Indeed, the children may not be as aware as the adults of the details and may even be somewhat skeptical about some aspects of the theory. What is important, however, is that everyone in the family believes that the family healing theory is a good working draft and will be acceptable until another is offered and accepted; that it is sufficient to keep the peace and get back to functioning like a whole family again.

#### *Phase V: Closure and Preparedness*

As the family begins to articulate their healing theory and negotiate its precise conceptualization, the therapist must begin to prepare the family for the end of therapy. This is done by beginning to review the specific objectives of the intervention program and encouraging the clients to recognize their accomplishments.

As the family enjoys a sense of accomplishment for working through the current crisis, the therapist should pose one or more crisis situations for their discussion. This allows the family to apply the insights and skills developed in the intervention program and to gain confidence that they will be able to face and overcome future adversities.



With the Burns family, for example, the therapist might ask one or more family members to describe how they would cope if fire destroyed their home, or if Mrs. Burns were hospitalized for several months, or if a pet died.

As another method of reinforcing the intervention, the family could be asked to serve as a role model to other families seeking assistance. If they agree, they might be called upon in the future to talk with another family in the process of recovering from a highly stressful event. The family could be reminded of how useful such a family could have been to them early in the treatment program.

The final session should convey a sense of accomplishment: that the family did it mostly on their own; that the therapist only served as a helper. They should be encouraged to write or call the therapist at any time, but urged to use the skills and insights they have developed in session to try to handle their own problems as they emerge.

I have found that it is useful during this phase to retest the family using the battery of instruments they completed earlier. Moreover, if the therapist is interested in regression effects, these same instruments should be administered again 6 to 12 months following therapy.

## CONCLUSION

This chapter presents a rationale for and approach to family therapy with the traumatized client and his or her family. The process is guided by four separate objectives: (1) to review the literature on the significance of the family to victim recovery; (2) to discuss the use of family therapy in treating traumatized clients; (3) to describe an approach to assessment of traumatized families; (4) to briefly outline an approach to family therapy with these families.

This approach emerged from a wide variety of scientific inquiries about families who do not ordinarily seek treatment. Indeed, the clinical literature, by focusing on psychopathology and dysfunction, frequently represents families—either implicitly or explicitly—as the cause of mental illness. Recent monographs, however, challenge this view and suggest that families in particular and social support networks and groups in general provide a vital and often overlooked function in fostering mental health and well-being (cf. Pilisuk & Parks, 1986). This approach assumes that the family was functioning acceptably well for all its members prior to the traumatic event. Moreover, victimized family members may



find more effective emotional support from sources other than the family, in the short run.

### *Future Research Requirements*

Obviously this approach is based on numerous assumptions that need to be tested and verified or changed. The major assumption of this approach to post-traumatic family therapy, for example, is that treatment should, at the very least, focus on the social supportive function of the family system and attempt to restore it at least to pre-trauma levels. This, of course, should be tested under rigorous scientific conditions in order to support or refute this assumption.

Moreover, by intervening at the family systems level, we believe that not only will the pain and suffering of members be alleviated, but, as a result of the intervention, the family will be more equipped to cope effectively with future challenges. This assertion, too, should be tested.

This approach to treatment certainly should be tested and contrasted with others. Assuming that this approach to post-traumatic family therapy is useful and appropriate, what are the implications for future research and treatment innovation? Certainly, traumatic events and the associated stress of individuals and systems directly affected have always existed. Most recently, traumatic stress studies have made significant strides in identifying the major reasons why people are traumatized and the process by which they recover. Moreover, the social support systems and the family in particular are extremely important resources in the recovery process. Comprehensive and effective intervention programs to prevent and treat traumatic stress must include some form of family treatment.

Beyond outcome studies, however, it is important to verify the findings of Kishur and Figley (1986), who found evidence of the chiasmal effect of the "transfer" of traumatic symptoms to supporters. Moreover, it is important to include studies of the incidence and prevalence of PTSD among various groups of victims and, additionally, evaluation of the closest supporters of these victims.

What is critical, however, are new studies of non-help-seeking people who have been exposed to traumatic events. From these studies we may begin to establish accurate estimates of the full human impact of highly stressful events, beyond the current estimates which include only those directly involved, the "victims." Among them we may find the hidden victims of traumatic events. What are the major differences between those who recovered from potentially traumatized events and



those who did not? What accounted for the speed and fact of recovery? Did the family and social support system play a role or was it a result of some other factor or set of factors, some of which have yet to be detected?

### Future Clinical Requirements

The field of family therapy emerged as a result of clinicians struggling with efforts to cure individuals with major mental illness. Today, the field of family therapy is quickly becoming one of the most powerful and promising in psychotherapy. Although few have discussed its utility in traumatic stress treatment, I hope that this chapter has illustrated the role of family therapy in treating not only the victim, but also the covictims, fellow family members, and the family system within which they reside. By selecting the *family as the unit of intervention*, we are assured of not only ameliorating the unwanted side effects of traumatic stress, but also equipping the family to cope more effectively with any future adversity.

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## SECTION II

# The Victim of Violent Crime

The relationship between victim and victimizer profoundly affects the meaning of victimization and the course of recovery. A wife who is terrorized by an assaultive husband suffers not only the traumatic effects of episodic beatings, but also the insidious loss of hope and will that accompanies a virtual state of slavery. This is compounded when representatives of criminal justice and welfare departments hold her, rather than her bullying husband, responsible for her plight.

A woman who is raped by a member of her family or a friend of her parent is less likely to press charges than a woman who is raped by a stranger. Questions of loyalty are raised, implying that the victim who breaks silence is perpetrating a crime against her kin!

The six-year-old child who is coerced into an incestuous relationship with her father is vulnerable to lifelong disruption of emotional and interpersonal functioning. The fundamental flaw is in the sense of self and the ability to gauge trustworthy relationships. This impairment is different and deeper than the acute effects of post-traumatic stress disorder. In fact, any significant traumatic event or series of traumas occurring in childhood may impair the normal development of personality, adding "axis II" disorders to the primary psychological distress.

And when a child is murdered, the parents and other family members must assimilate images of horror and feelings of guilt along with their grief.

This second section is devoted to those circumstances of victimization in which the crime has special significance to the victim or the surviving



kin: domestic violence, rape, incest, and the assault and murder of children. Specialists have amassed scientific evidence to support their intervention strategies in these discrete areas.

Anne Flitcraft and Evan Stark began working with battered women as founding members of a shelter project in New Haven, Connecticut. Dr. Flitcraft's thesis at Yale Medical School developed into a five-year collaborative study of the prevalence of deliberate injury to women. She and her husband, Professor Stark, defined the "adult trauma screen," which is rapidly becoming a standard medical device for identifying victims of abuse. Their perspective is feminist, emphasizing gender politics rather than personal pathology, and they conclude that health care providers, including psychiatrists and social workers, directly contribute to the entrapment of women in violent homes through neglect, minimization, and victim blaming.

Carol R. Hartman is the coordinator of the Graduate Program in Psychiatric Nursing at Boston College. Originally interested in the impact of maternal psychosis on the development of children, she expanded her scope to include the effects of traumatic experience and deprivation. This coincided with her colleague's, Dr. Burgess', pioneering work on the impact of rape and sexual exploitation on children and adults. Throughout the years their collaboration has increased, as well as the breadth of their research and clinical practice, focusing on post-traumatic reactions to sexual assault.

Ann Wolpert Burgess, Professor of Psychiatric Nursing, has investigated the use of children in pornography, heart attack victims and return to work, sexual homicide and patterns of crime scenes, and linkages between sexual abuse and exploitation of children, juvenile delinquency, and criminal behavior.

Judith Lewis Herman is the author of *Father-Daughter Incest* (Harvard University Press, 1981), which won the C. Wright Mills award from the Society for the Study of Social Problems for its analysis of incest. Dr. Herman is a founding member of the Women's Mental Health Collective, a woman-controlled clinic in Somerville, Massachusetts, and a member of the clinical faculty of Harvard Medical School.

The author of the chapter on victimized children, Carol T. Mowbray, is principal investigator for the DHHS grant "Out of Home Child Sexual Abuse: Its Impact and Correlates." As Director of Research and Evaluation for the Michigan Department of Mental Health, she has supervised several large studies concerning rights protection for mental health service recipients, mental health needs of the homeless, and typologies of services for the chronically mentally ill. She chairs the Department's



Action Committee for Women, which makes policy recommendations to improve services to female mental health clients.

Ted Rynearson is a clinical psychiatrist in full-time practice in Seattle, Washington. His research and teaching interests and administrative duties are of secondary importance to his role as primary clinician. His interest in bereavement has been enforced by his patients. He writes, "The long-term adjustment to separation and loss is so ubiquitous that a solid understanding of its clinical effects and therapeutic intervention has been a necessity. The syndromal effects of unnatural dying has been an area of particular interest." Dr. Rynearson has made an effort to elucidate this as a coherent clinical syndrome.







# *Personal Power and Institutional Victimization: Treating the Dual Trauma of Woman Battering*

EVAN STARK and ANNE FLITCRAFT

Legally, "domestic violence" subsumes any act of assault by a social partner or relative, regardless of marital or parental status, severity of injury, or accompanying psychosocial problems. The term "abuse" highlights the unequal power relationship in which the assault occurs and suggests that a presumption of trust has been violated. Prefacing abuse with the term "spouse" indicates concern for males assaulted in intimate relationships as well as females and for relationships in which both partners are equally abusive (intrasposal violence). However, although clinicians must be sensitive to wife-husband assault and abuse between same-sex lovers, the complex psychosocial profile associated with battering has been identified only among women.

Battering and abuse are sometimes used interchangeably. But this ignores the important distinction between an initial assault (abuse) and the life-threatening history of injury and psychosocial problems which signals entrapment in a battering relationship. Reviewing the medical records of 3,676 women presenting with physical injuries at a metro-

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politan hospital, Stark (1984), Stark et al. (1979, 1981, 1983), and Rosenberg, Stark, and Zahn (1986) identify a *battering syndrome* among abused women in which a history of trauma is accompanied by a disproportionate risk of rape, miscarriages and abortion, alcohol and drug abuse, attempted suicide, child abuse, and mental illness. This multiproblem profile includes a history of help seeking marked by neglect and by inappropriate and punitive responses. For an estimated 25% of abused women, a single assault is an isolated episode (Teske & Parker, 1983). But for the majority of abused women, a risk of battering must be assumed unless there is compelling evidence that violence has stopped. This chapter focuses on the clinical dimensions and treatment of battering, the syndrome attendant upon spouse abuse and characterized by a history of injury (often including sexual assault), general medical complaints, psychosocial problems, and unsuccessful help seeking.

Just why abuse is followed by battering only among women remains unclear. The two most common answers, that women are masochistic or, conversely, that they accept their fate because of some combination of fear, environmental disadvantages, and personality deficits, are unsatisfactory. Although abuse may evoke a number of mental health problems, there is no evidence to support the claim that a substantial number of battered women derive pleasure from violence or choose to remain in violent relationships when viable alternatives are offered. To the contrary, as we indicate below, abused women make frequent efforts to escape the violent relationship and are typically forthright about the source of their problem. Meanwhile, abused women come almost as frequently from white, middle-class homes as they do from low-income or minority families. And the personality problems most frequently associated with abuse, such as low self-esteem and depression, are usually situationally induced and, in any case, are not peculiar to battered women.

The reason why women stay lies less frequently in psychological principles than in an understanding of how, by constricting women's autonomy and closing off their options, the systems to which abused women turn for help contribute to their somatic, psychosocial, and interpersonal problems. The modal experience of battering is a dual trauma, fear and anger induced by violent subjugation combined with a sense of increasing entrapment. Abused women appear "passive and withdrawn" or inappropriately hostile, presentations easily misread as signs of inner deterioration. Typically, however, their sense of entrapment is a reality-based response to a history of denial, minimization,



and victim blaming by those from whom they have sought support and protection, including police, doctors, social workers, and therapists. As a result, battered women are often surprisingly responsive to short-term counseling where a sense of personal security is developed through protection, empowerment, and advocacy. How the helping system contributes to entrapment and the dilemmas (and opportunities) for therapy that result from the dual trauma of woman battering are the topics of this chapter.

## THE BATTERED WOMEN'S MOVEMENT

A century ago, women stayed with violent men because there was no alternative. Nineteenth-century feminists believed, somewhat naively, that male tyranny in private life would disappear as women gained formal rights to divorce, custody, property, the vote, and equal protection under the law. When this didn't happen, when it became clear in the 1960s and '70s that perhaps as many as 8 million women in the United States were in abusive relationships despite their hard-won entitlements, researchers and service providers presumed that personality factors explained why abused women failed to take advantage of their rights. It is easier—and safer politically—to probe the childhood experiences and/or psychological motives of violent men and their victims than to ask whether the institutions to which women had gained access—such as the police or court system—might not be undermining their formal entitlements to security, health, and autonomy.

The battered women's movement posed an important alternative to the reductionist explanations and treatments of abuse. Within the context of this movement, we encountered women whose independence, competence, strength, and courage stood in marked contrast to the dominant portrait in the professional literature.

An old friend, Sharon Vaughn, helped start an early battered women's shelter in St. Paul. When we visited her at Women's Advocates in 1976, she was writing grants in a third-floor attic. Downstairs, abused women answered phones, prepared meals, provided day care, and ran peer counseling. New residents signed a "contract" that included regular household responsibilities, specific objectives for personal change during the shelter stay, and an agreement to help other residents meet their service needs. The group was adversarial but effective.

We have never called women needing help "clients" or "cases"



and this has not prevented effective communication with the professional community. When we were told that only trained and certified professionals could run the house, we insisted that professional credentials not be included as job requirements. We asserted our belief that women in need of shelter were not sick . . . emphasizing instead their need for safety, support and help with practical problems. [cited in Schechter (1982), pp. 63-64]

More than 700 communities now host similar shelters. The most impressive quality of the women who fill these "safe houses" beyond capacity is a fierce independence bred from skills needed to survive violent relationships. When a woman first calls the "hotline," we may plan her escape step by step. And even in a new home, the phone ringing or a sudden knock on the door can evoke severe anxiety. On most occasions, however, and particularly when they act in concert, these same women are assertive, examine their predicament realistically, and are skillful at negotiating for their service needs.

We will never forget visiting Chiswick House in London, the first battered women's refuge. Ninety women and children crowded the eight-bedroom Victorian house. But the air was electric with excitement. Even the disorder instilled confidence that if this chaos could be managed, anything could. That night, armed with wallpaper, basic tools, and portable toilets, a group of the women "liberated" an abandoned railroad hotel. Within hours, the building was livable, even attractive, and full. A similar creative energy led 15,000 women to call the Public Broadcasting System during a two-hour period following a special on "Battered Wives, Shattered Lives." Wherever bridges have been built, battered women cross them.

The grass-roots origin of battered women's shelters and their emphasis on peer support and advocacy contrast with professional dominance in other areas of family violence, such as child abuse. As in the child abuse field, professionals working on woman abuse predominantly view injured parties as victims requiring rescue and draw on psychological theories of victimization which emphasize dependence, low self-esteem, learned helplessness, and other personality deficits. By contrast, the battered women's movement defines abused women as "survivors" requiring empowerment. Shelters have many shortcomings. But their rapid spread as a viable alternative to the violent relationship makes it easy to forget that in less than a decade grass-roots women and volunteers have invented an entirely new institution whose "success" compares very favorably to more conventional treatment approaches,



whether judged by crude recidivism or by long-term benefits to women and children.

Perhaps more sobering, the advocacy-coaching model employed by shelters is effective partially because the official helping response is one component of a woman's problem. Abused women use the same terms for both professionals and assailants. Neglect, denial, minimization, and victim blaming are the most common complaints. Stories range from being called crazy or a hypochondriac, through being "cooled out" with drugs and advised to "stick it out," to the punitive removal of children, unnecessary mental hospitalizations, and shock treatments. Abused women who are also alcoholics describe being denied care altogether or, worse, being triaged to settings where sanctions are used to pressure them to remain in violent situations. These experiences undermine a woman's capacity to understand or act on her predicament.

Subsequent sections draw out the treatment implications of women's help-seeking experience. But first, we present a fuller clinical description of battering. A strictly medical approach might conceive of a syndrome solely in terms of proximate interpersonal factors, injuries, and personal suffering (as in the "battered child syndrome," for example). In battering, this conception must also encompass the institutional and cultural milieu (including the medical response itself) in which abuse—an act of domestic assault—evolves into a pattern of entrapment.

## WHAT IS BATTERING?

### *The Battering Syndrome*

Surveys reveal that the incidence of woman abuse in the general population is many times higher than indicated by records of medical and mental health visits (Straus et al., 1980). The prevalent explanation for this gap is that victims conceal their problem due to masochism, low self-esteem, or a "helplessness syndrome" induced by repeated acts of violation. What sensitive questioning and a careful reading of medical records show, however, is that this discrepancy reflects clinical neglect and minimization of violence rather than a woman's reluctance to report. Women's records indicate, for example, that only one abused woman in 20 who seeks medical services is properly identified (Stark et al., 1979). Similarly, when clinician-patient encounters were observed, Kurz and Stark (1987) learned that while 75% of the battered women volunteered the information that they had been abused, the problem



was acknowledged in only 5% of the cases. Hilberman and Munson (1977-78) questioned women at a rural mental health clinic and found that abuse had been properly identified in only 1 case in 15. The clinician who notes "hit by ashtray" or "stabbed with knife" fails to probe how these inanimate objects were propelled through the air.

The failure to identify abuse means institutional statistics grossly underestimate the problem. One source that is independent of official recognition is a woman's adult "trauma history." By assessing the probability that injuries recorded on women's medical charts are deliberately inflicted, we can estimate the true prevalence of abuse in clinical settings, identify its most salient psychosocial dimensions, and assess the professional response.

*Prevalence and injury.* The most astounding aspect of woman abuse is its prevalence and duration. Using a trauma screen among a year's random sample of women patients, we found abuse to be the single most common source of female injury brought to medical attention. Nineteen percent of female injury patients were "battered women," a finding replicated by a Philadelphia study (Kurz & Stark, 1987). Meanwhile, 16% of all female injuries are the direct result of abuse (auto accidents account for 11%) and another 24% (or a total of 40%) occur in the context of abusive relationships (Rosenberg et al., 1985; Stark & Flitcraft, 1987). One-third of all sexual assault ("rape") occurs in battering relationships (Stark et al., 1979). As important, abuse is typically ongoing. Half of all abused women are beaten several times a year and many are beaten as frequently as once a week.

Although we tend to view battering as a physical emergency involving primarily severe injury, its prevalence and duration make it an ongoing facet of women's ordinary help seeking. As a result, battered women comprise an even larger segment of "nontrauma" caseloads (such as obstetrics) than of emergency patients. Its psychosocial dimensions are just as important. Compared to nonbattered women, abused women are 5 times more likely to attempt suicide; 15 times more likely to abuse alcohol; 9 times more likely to abuse drugs; 6 times more likely to report child abuse; and 3 times more likely to be diagnosed as "depressed" or psychotic. The absolute numbers are as significant as the relative frequencies. For example, 19% of all battered women attempt suicide at least once, 38% are diagnosed as "depressed" or having another situational disorder, and 10% become psychotic. The resulting impact on mental health is enormous. Almost a third of psychiatric inpatients and outpatients are battered (Carmen [Hilberman], Rieker, &



Mills, 1984b; Hilberman & Munson, 1977-78). And battered women comprise 26% of all women who attempt suicide (and 50% of black women who attempt it), 30% of female alcoholics (Stark, 1984), and 45% of the mothers of abused children (Stark & Flitcraft, 1985).

These facts fail to answer two questions that underlie every discussion of woman battering. Is victimization the consequence or the cause of accompanying psychosocial problems? And why do women stay? The evidence should dispel myths that attribute abusive violence and ongoing victimization to underlying psychopathology or to some combination of psychopathology, personal deficits, and "stress."

*Politics or pathology?* The psychosocial complex associated with abuse and the multiproblem families from which many shelter residents come has led observers like Erin Pizzey, founder of Chiswick House in London, to conclude that many battered women are "violence prone." Either abused women evoke violence from men by being "masculine," "frigid," "overemotional" with "weakened ties to reality," and have "inappropriate sexual expression" (Contoni, 1981; Scott, 1974; Snell et al., 1974), or they accept victimization owing to their socialization, low self-esteem, and the helplessness produced by repeated attacks (Walker, 1979). In explaining why men batter, a psychological emphasis on childhood abuse is supplemented by learning theory. Most writers view violence as a response to stress learned from childhood maltreatment, supported by cultural norms and transmitted across generations, particularly in inner-city "subcultures of violence" or in "violent families," where abuse circulates from one member to another.

Feminists reply that the problem is not violence per se, but male violence used to control women and other family members, and they insist that abuse, like rape or child sexual abuse, results from male domination (and the resulting inequity in power and resources), not psychological difficulties. Since the politics of gender inequality is the major issue, intervention should target situational rather than psychological factors.

A growing body of evidence supports the view that abuse is elicited by conflict over women's role stereotypes more often than by family history, psychopathology, or personality deficits (Stark & Flitcraft, 1987). Comparing the onset of abuse and other problems among battered women, we found that abused women experience a greater risk of alcoholism, attempted suicide, mental illness, and child abuse only after a history of assault is presented. In other words, battering is the context for psychopathology, not the reverse. Women abused as children are



more likely to become battered adults, and abused boys are more likely to be batterers. But the majority of batterers (around 90%) and of survivors (75%) have no history of assault as children (Stark & Flitcraft, 1985). Nor are abused women in other problem populations disproportionately from violent or disturbed homes. So, for instance, while 45% of all child abuse may be accompanied by the mother's abuse, the assaultive male is the typical child abuser in these cases, and the battered mothers are less likely to come from alcoholic, disorganized, or violent homes than nonbattered mothers of abused children (Stark & Flitcraft, 1985). By contrast, the sexual nature of abuse is suggested by the frequency of abusive injury to the face, breast, and abdomen; the close association of battering with rape; and the fact that fights leading to abuse typically involve money, sex, child care, or housework (Dobash & Dobash, 1979).

*Marital status, income, and race.* Demographic information further supports an emphasis on gender conflict rather than family process of environmental stresses such as poverty, racial discrimination, or unemployment. Single, separated, and divorced women are actually at greater risk for abuse than married women (Stark & Flitcraft, 1987), and abuse among poor, black, or unemployed women is only 3% higher than among white, middle-class, or professional women (Schulman, 1979).

*Personality factors.* Few, if any, personality differences have been found between abused and nonabused women. Indeed, abused women often have a better sense of reality than their assailants, are more "social" and "sympathetic" than controls, and exhibit greater ego strength (Finn, 1985; Graff, 1980; Star, 1978). Frequent suicide attempts by abused women suggest that some turn anger inward. But a substantial number are outwardly aggressive, independent, or overtly hostile to their assailants. Lenore Walker, the psychologist who first applied the theory of learned helplessness to abuse victims, now argues that these women are independent, aggressive, and highly motivated, rather than helpless (Walker, 1983). And when Michigan housewife Francine Hughes poured gasoline on her ex-husband's bed, took their children, and then burned the house to the ground, her murder trial—and acquittal by reason of temporary insanity—became a *cause célèbre*. Finally, noninstitutionalized abuse victims do not typically evidence the low self-esteem or self-blame reported among abused mental patients, suggesting that hospitalization may be one source of low self-esteem for these



women or, as likely, that low self-esteem is situational rather than characterological.

Unfortunately, the myth that battering arises from psychological or environmental dysfunctions is not easily shaken. Psychological explanations exert a strong hold on service providers whose institutions have a vested interest in therapy and welfare rather than political change. Abused women have multiple problems, making it easy to see them as "victims" needing rescue. Batterers, like many other distressed men, have suffered pain in their childhood, often including physical maltreatment. And it is safer to trace violence to childhood neglect and focus current treatment on a man's "impulse management" than to confront the health consequences (for men as well as women) of patterns of control and dependence that are widely considered normal. Obviously, until women can be assured safety and adequate support, emphasizing psychological dependence is victim blaming. Yet even experienced shelter staff rationalize the understandable frustration and anger they feel when a woman returns to a violent relationship by blaming something "in" her. It is extremely hard to see the strengths of women who may present themselves as passive and overwhelmed with problems.

As much as we resisted it, we too were slowly seduced by the conception of abused women as psychologically deficient. The clinical histories we reviewed were pictures of pathos and personal devastation. The same story was repeated with an almost fatal regularity. An abusive episode was presented, then, perhaps in a few months, alcoholism or drug abuse appeared, then more injury, mental illness, rape, more injury, attempted suicide, and psychiatric hospitalization. This tragic progression seemed so automatic, the rhythm with which personal self-destruction followed injury so natural, the cumulative impact of professional intervention so minimal that the myths about masochistic or violence-prone women appeared valid.

Fortunately, our continued work in the battered women's movement helped us recognize that the clinical record of pathos was less an objective picture of women's lives than a profoundly biased justification of what clinicians felt and did when they were confronted by abuse. Clinicians were being passive-aggressive by recording women's escalating problems but taking no cognizance of abuse or of how their own failure to respond appropriately might be contributing to escalating problems. The resulting image of victimization and helplessness rationalized the withholding of care. Worse, clinicians projected their own resistance to the woman and then read it back as reluctance on her



part. Then, this "reading" was enforced through minimization of the violence, victim-blaming labels, and a range of punitive interventions whose cumulative effect was to so reduce a woman's autonomy that she became the passive, multiproblem victim of circumstances that had originally been projected. The clinical "facts" portrayed women whose souls have been crushed by an inscrutable and hostile other. What we learned was that the clinical response had a good deal to do with these facts.

### *The Dual Trauma of Abuse and Victimization*

A picture slowly emerged of battering as a complex of physical and psychosocial problems evoked by personal violence that has become enmeshed with a history of institutional neglect and inappropriate interventions. Problems of omission are the easiest to detect. Lack of identification is accompanied by a failure to follow abuse victims clinically, even when they attempt suicide. Interestingly, however, although abuse is not officially acknowledged, abused women are treated differently than other women. What we call an "implicit diagnosis" starts with denial of care or the prescription of inappropriate pain medication, progresses through the frequent use of tranquilizers, and often ends with frankly punitive referrals to state institutions. Abused women who are alcoholics receive virtually no care (Kurz, 1987). Meanwhile, compared to nonabused mothers of abused children, abused mothers are more likely to have their children placed in foster care regardless of who is abusing the child (Stark & Flitcraft, 1985). Indeed, in New York and many other states, a child may be removed simply for witnessing a mother's abuse. Perhaps the stereotypic female labels are most insidious. As problems mount in the face of clinical insensitivity and inappropriate care, abused women are reported to be "hypochondriachal," "crocks," hysterics, "well-known women with vague complaints," and "TBPs" (trans. "total body pain"). Within health care, labeling is a process of metacommunication that legitimates nonintervention, isolation, perfunctionary treatment, and punitive care.

Physical abuse leads to disfigurement, incredible pain, fear, and psychological suffering. But the total subordination that marks woman battering requires that avenues of help and escape be both literally and psychologically closed by neglect or no follow-up, labeling, inappropriate medication, and referrals that tell a woman she—not her assailant—is the source of the problem. This process of entrapment which is built



up around abuse is evoked by the institutional response to persistent help seeking.

Either or both social partners may be hit in a fight. Surveys even suggest that women hit men as often as they are hit (e.g., Straus et al. 1980). But only women suffer the dual trauma of interpersonal assault and institutional victimization based on subordinate status. Both in their personal relationships and in their helping encounters, battered women are subjected to unquestioned assumptions that reflect wider stereotypes regarding women's character, appropriate behavior, and normal family forms. Embodied in a range of helping responses, these assumptions have direct, severe, and long-term consequences for victims of abuse. Though some women have impaired esteem to start, for most, entrapment and despair only follow a history of frustrating—even punitive—help seeking. Neglect, inappropriate medication, labeling women who persistently seek help, and stigmatizing abused women with secondary problems (such as alcoholism) so that their access to care is effectively blocked—all undermine women's credibility, isolate them, and reinforce behaviors, such as submissiveness and compliance, which increase vulnerability to abuse.

Once we recognize how institutional maltreatment evokes the apparent "deterioration" of abused women in the clinical population, we can understand the restorative power of the shelter experience and the importance of incorporating its operating principles into post-traumatic therapy. The women in the shelter and the women whose records we read are really not two separate groups, but the same women in different settings. The shelter's "survivors" differ from the "victims" needing to be rescued because the supportive milieu of the woman's space stands as an alternative to the dual trauma of violence and institutional victimization. By setting self-reliance and advocacy in the context of mutual recognition and collective support, the shelter reawakens a woman's capacity for social autonomy, including independence in public service settings, as well as in her personal life.

Against a background of protection and negative sanctions for violence, the task of therapy is to facilitate and extend the dual empowerment process. The relative effectiveness of the shelter experience is a function of the duration of violence, the complexity of accompanying psychosocial problems and a woman's history of institutional maltreatment. Conversely, the support a woman receives in the shelter may be the key to resolving the many situational dilemmas in which her quest for selfhood and autonomy have been pitted against personal



safety and the need for help and other survival resources, both social and material.

### *The Challenge to Traumatization Theory*

Woman abuse is a situational response to real or perceived threats to male prerogatives. Woman battering—the entrapment process that evokes psychosocial problems alongside escalating injury—follows when institutional neglect, isolation, and maltreatment are added to assault. If women's vulnerability to abuse in "family fights" originates in their relative lack of resources, it is extended, against women's claims to independence, by interventions whose cumulative effect is to reproduce the context of unequal power in which male authority can be exercised arbitrarily (i.e., violently). Women seek relief from domination. But when blame is transferred to the woman, effectively punishing her for seeking help, her resistance to domination is managed, not domination itself. Appropriate intervention works back from crisis intervention to prevention. Once a woman is safe (because of shelter, for example) and the violence is stopped by police or the courts, the process of empowerment—of breaking the links between violence and control—can begin.

Traditional mental health views violence as symptomatic of underlying psychiatric or behavioral problems for which individual counseling and/or couples' and family therapy is appropriate. By minimizing violence, this model colludes with the assailant's tendency to deny or minimize his acts. Meanwhile, when it reinterprets a woman's abuse as a problem of mutual responsibility or, worse, as a function of inherited, behavioral, or psychosocial problems that "belong" to her, traditional therapy unwittingly allies itself with the larger system of discrimination and with forces in the family that are also defining the problem this way (Imber-Black [Coppersmith], 1986).

The traumatization model breaks with this approach, emphasizing that violence (as in the case of assault), personal violation (as in incest or rape), and kidnapping are sufficiently traumatic in themselves to evoke a predictable constellation of feelings and behavior only minimally related to individual differences. In assuming the victim's perspective, it takes an ethical as well as a therapeutic stance and refuses to compromise a person's right to physical safety because s/he exhibits apparent symptoms of psychiatric disease. This is particularly important in battering, where the etiological links between violence and its sequelae become masked by myriad behavioral problems. Assuming that violence



has stopped, principal treatment objectives are to overcome the sense of physical and psychological violation and restore a sense of autonomy and separateness.

However, despite the many advantages of a victim-oriented framework, battering challenges the traumatization approach in several important respects.

1. The traumatization model has been applied mainly to cases, such as stranger rape, war trauma, or kidnapping, where the traumatic episode(s) and the "post-traumatic" reaction can be clearly demarcated. The ongoing nature of battering often makes this demarcation impossible. Fears, feelings, and behaviors appropriate to current entrapment can easily be mistaken for post-traumatic paranoia, depression, or powerlessness. Because treatment often begins with the patient still at risk, confronting the violence is the first imperative. Although some therapists believe it is impossible to do meaningful therapy with women at risk, the practical context often necessitates working through this dilemma.

2. As in the discussion of "rape trauma syndrome," a post-traumatic framework may identify symptoms solely with the act(s) of assault or violation, thereby missing the importance of institutional trauma and the extent to which the symptoms of battering function in a wide social interplay that reaches beyond physical assault to the experience of therapy itself. Here too, reality-based reactions to the illegitimate exercise of institutional authority may be misinterpreted as personality problems: justifiable anger at professionals may be misread as "resistance," real powerlessness may be misread as "depression," or myriad help-seeking efforts may appear to be "overinvolvement" (Imber-Black [Coppersmith], 1986). In providing a corrective to the psychoanalytic emphasis on personal pathology, post-trauma therapy should seek out the complex ways in which subordination in institutional and intimate encounters has built up over time.

3. In underplaying the political dimensions of a problem, post-traumatic therapy can inadvertently reinforce the dependence it seeks to overcome. Although the abused woman may be in the throes of a compensatory and reactive behavior pattern over which she has little control, a successful treatment outcome must accommodate her underlying quest for autonomy. By overemphasizing a woman's victimization, a post-traumatic stress model may underestimate the importance of this quest and, in turn, seek to rescue her rather than support her choices. For some battered women, violence is the only issue, and entrapment results directly from limited options or paralyzing fear. But although



all battered women want the violence to stop, as paradoxical as this may seem, many victims experience the violent reaction as an integral part of a power struggle through which they seek to develop their personality and express their independence. These women may have great difficulty conceiving of the violence ending without fundamentally compromising or even abandoning their goals for personal growth. Helping the woman without inadvertently reinforcing dependence presents an ongoing dilemma during treatment.

The time-limited situational interventions required to deal with the traumatic consequences of battering appear to be relatively straightforward compared to the complex issues raised by long-term psychotherapy. Paradoxically, however, mental health practitioners are ill prepared to confront the personal, ethical, and professional dilemmas raised by battering or to unequivocally support female empowerment as an alternative to traditional dependence.

To successfully overcome battering, the rational core of the victim's response to the violence and to inappropriate and punitive care must be elicited and supported. The first step in differentiating what the patient has done (and why) from what has been done to her is a full history of personal trauma as well as of her help seeking. The impact of physical abuse has been widely discussed elsewhere. (Dobash & Dobash, 1979; Rieker & Carmen, 1984). However, the ways in which systemic maltreatment intersect with intimate violence have been relatively neglected. The following case histories illustrate how the helping response impinges on the victim's experience and show why understanding the process of institutional victimization is so crucial to post-traumatic treatment.

#### THE CASE OF MRS. SMITH

It is far easier to accept the abused woman as the dependent victim who first appears in the office than as the persistent and aggressive woman who emerges after the history of help seeking is elicited. Nothing is more difficult during the recovery process than separating this aggressiveness—without quashing it—from the anger and violence it evokes in a particular man (or helper). And supporting personal autonomy is made even more difficult by our own profound ambivalence toward aggressive women or "troublemakers" and our desire to rescue victims by getting them to do what we think is best. In the following



case, persistent help seeking is met with labeling, conferring on Mrs. Smith the status of a "deliberate deviant" (Roth, 1972; Kurz & Stark, 1987). As a result, abuse is concealed and punitive interventions are justified—including denial of care and hospitalization in a state institution—which reinforce the impact of the husband's violence.

The narrator is director of education and training at a prestigious psychiatric institute. He calls the case "The Typical Crock" (Bauermeister, 1979).

Mrs. Smith came to this country from Eastern Europe in 1914, worked as a domestic in Washington, DC until 1928, when she moved to a medium-sized university town in New England to marry. During the next 40 years (from 1928 to 1967) she saw 394 physicians (including 17 psychiatrists), averaging a visit a month, or 425 visits overall (340 nonpsychiatric, 84 psychiatric). Despite an "unremarkable" history, Mrs. Smith repeatedly complained of problems with her head, eyes, ears, face, throat (12 times), chest, breathing, vagina, and so forth, in addition to ill-defined "pain all over." She did not receive elaborate workups, however, since her problems were "transparent." As a consequence, she received no follow-up, most of her visits were unscheduled, and no diagnosis was made, therapy suggested, or return visits scheduled. On the contrary, resentment of her "psychosomatic disguise" provoked psychiatrists to use labels for Mrs. Smith such as "crock," "immature personality," "hysterical," "emotional overlay," and "conversion reaction," and she was eventually committed to a state mental hospital for "punitive" reasons. (p. 211)

There is no malevolence behind the gradual transformation of Mrs. Smith from a persistent help seeker into a "deliberate deviant" for whom "nothing can be done." The process is defensive. Frustrated by the patient's refusal to respond to treatment, clinicians project their disappointment onto her, then read it back as an inadequacy in her. The narrator sincerely believes that if Mrs. Smith had only been recognized as "a typical crock" early on, valuable time and resources would have been saved and she would have been spared an admittedly punitive hospitalization. Somewhat paradoxically, the key to managing this "all too common figure" is the discovery that nothing can be done to help her.

Returning to her medical record, we discover that in 1928, the same year Mrs. Smith began her "transparent" career as a "crock," her husband began beating her "regularly." He is described as "psychotic"



and "aggressive," presumably because of the beatings she reports. But these observations are never associated with her multiple physical and mental health complaints. To the contrary, since it predicts frequent, unscheduled visits and requires no follow-up, the diagnosis "crock" is well suited to a family situation where violence, hence injury or other problems requiring medical attention, is sporadic. Mrs. Smith makes many of her "unnecessary" visits simply to call attention to her plight. But her pleas for help are diagnostically reorganized until the problems she has reveal the problem she is, for herself and for her helpers, and conceal the real etiology of her "multiple vague complaints." The term "crock" translates the interns' moral judgment into clinical terms (from bad to mad, as Laing might say), presumably evoking professional behavior in place of the more arbitrary response to frustration. Her persistence is converted from a problem for her doctors into a symptom of an underlying pathology. She has so many complaints and problems because she is the sort of woman who has so many complaints and problems. Thinking ahead, we can anticipate how the label "crock" can enter the situation it fails to grasp, weaken her sense of reality, and even generate the "psychosomatic disguise" expressed through complaints in breathing and of pain to parts of her body that have been previously attacked.

A full explanation of why psychiatrists and physicians respond this way is beyond the scope of the chapter. At a minimum, it would include the limited grasp of social ills afforded by the medical paradigm, the administrative pressure to manage "overutilization" whatever its source, and, within the encounter itself, the dilemmas clinicians feel when aggressive women confront them with "the failure of the cure." Luckily, Mrs. Smith is "transparent." She has been "seen through" (the literal meaning of diagnosis). The "failure" is relocated in her; valuable resources are preserved by denying follow-up; and the medical paradigm is preserved by showing that a problem ostensibly outside its grasp is really no problem at all. Like the assailant at home, medicine responds to Mrs. Smith's autonomy by depriving her of resources and making her the object of management.

The course of treatment over time is linked to stages in the development of battering. At the outset, physical problems and complaints are treated symptomatically—pain medication for headaches and tranquilizers for anxiety, for example. Next, "accidents" escalate beyond the comprehension of symptomatic care, and secondary psychosocial problems develop. Now psychiatry takes over, reinterpreting the woman's history, including the maltreatment at home, as the consequence of her



irrational need to call attention to herself (in this case) or of secondary problems such as alcoholism. Finally, severe psychosocial and life-threatening physical problems emerge, frequent suicide attempts for instance, and are met with frankly punitive interventions (state hospitalization in this case, the removal of children in the next) or interventions designed to treat the secondary problems in the context of the violent family structure. As her diagnosis progresses from "bad" to "mad," her reception evolves from poor medical practice to systemic maltreatment.

A common feature of these cases is the undermining of a woman's capacity to seek appropriate protection from danger, a key survival skill. Her ability to struggle at home is reduced, she feels there is no place to turn—a frequent source of depression and homicidal rage among abused women—and she forms an inner association between personal initiative and rejection that is displaced in alternating patterns of passivity and undirected aggression. Forced to seek help for her primary problem through a number of indirect means, Mrs. Smith begins to somatize and confound her physical, psychological, and behavioral problems until she herself becomes tentative, perhaps unsure, about what her major problem actually is.

The projection of problems in institutional management to Mrs. Smith parallels the process of individual countertransference in certain respects. One difference is that the transference of institutional problems to abused women is enforced by withholding resources vital for their survival. In this respect, one function of advocacy is to get medicine to confront and assume responsibility for its own hostile projections.

#### THE OVERCONTEXTUALIZATION OF MRS. McSHANE

The experience of Mrs. McShane demonstrates how a negative helping response can "enter" and aggravate a violent relationship by reducing a woman's autonomy and credibility. Over time, abused women often react to the punitive helping response by somatizing their search for aid, concealing it behind a feigned dependence or by alternately presenting as fatigued and numb or agitated and overtly hostile. The presentation of "vague complaints" of pain with no apparent organic basis is a plea for help by other means. As these complaints are interpreted as further evidence that no follow-up or referral is needed, secondary problems such as suicide attempts escalate in frequency and



severity, and managing mounting anger becomes increasingly difficult. Race and ethnicity influence whether building rage presents as free-ranging aggressiveness (e.g., loud talk, flailing arms, threatening behavior) or as superficial calm punctuated by violent outbursts. In the latter case, as Carmen (Hilberman) et al. (1984b) caution, passivity and denial of anger do not mean that the abused woman likes or has adjusted to her situation. On the contrary, feelings are withheld in response to the double-bind women experience when, after they describe their predicament, aid is withheld. Rage ultimately penetrates the wall of outward passivity: one abuse victim in five attempts suicide at least once (and 1 in 10 does so multiple times) and many abused women murder their assailant, as in this case. It is crucial, therefore, that a woman's efforts to circumvent or otherwise overcome the refusal by helpers to treat her appropriately not be interpreted as proof of psychiatric disease or as a rationale for perfunctory treatment.

This case history is reconstructed from clinician notes, prescriptions, and referrals.

### *Case Presentation*

Mrs. McShane first came to the emergency service with trauma in January 1977, saying she had been hit with fists on her head and abdomen. She was three months' pregnant and had three small children. She was treated and referred to the women's clinic, the hospital's obstetrical service.

Less than a month later, she returned to the emergency service saying that her boyfriend struck her on the head, causing her to hit her head on a wall. She reported that water was released and she had noticed bloody spotting since he hit her. A number of black and blue marks were visible. She was examined by the surgery and gynecology services and again referred to the women's clinic.

A month after giving birth, Mrs. McShane returned again, saying that her boyfriend beat her severely with a club. She was treated for multiple contusions on her legs and arms, a large hematoma on her head, a laceration on her right hand, and a dislocated left thumb. The surgery service referred her to psychiatry, where it was noted:

. . . she is a 24-year-old black female who has been beaten multiple times in the past and presents after severe beating today . . . she lives alone with her four young children and is in much pain and overwhelmed with problems.



She was referred to family counseling for follow-up, and then sent home, only to return in a few hours because "she can't care for her four children (all under six) with both hands splinted." She was admitted for "rest and care and help with social situation." The text of her admission, written by social service, reads in part:

I saw this patient yesterday in the emergency room. She presented herself as nervous and I felt that she was postpartum depressed. She requested voluntary inpatient psychiatric help preferably at the community mental health center as she felt too nervous to go home. I asked psychiatry to expedite her referral. She was seen by psychiatry and referred to Family Service. . . . Her last pregnancy was particularly stormy and she wanted to abort the fetus. She reports that physicians felt she was carrying a stillborn and then discovered fetus was viable and too late to abort. Mrs. McShane worried throughout her pregnancy and is still worried that her baby may be abnormal. In addition she did not want this baby. The baby's father and she have had a very problematic relationship. . . .

The social service notes continued:

She was raised in a "cruel" foster home until age 12 at which time she went to live with her natural father for two years. Both her foster parents and her natural father beat her. She describes herself as having been abused as a child. Her father has a drinking problem. . . . It is apparent to me that this patient's current admission might have been avoided if her need for psychiatric hospitalization had been realized when she was initially seen in the emergency room.

A note from psychiatry is included: "Patient was beaten up by boyfriend who is in jail. . . . She is requesting admission to a psychiatric ward in any hospital." However, the next day, Mrs. McShane was discharged home with a cane and follow-up by visiting nurses.

In 1978, Mrs. McShane was pregnant again and on three occasions presented with bruises. After the first reported trauma, she was given Dalmane to help her sleep; after the second, Darvon for pain. She had called the police, had moved in with her sister, and was "very depressed." Shortly after the delivery, the visiting nurse reported that though the mother complained of fatigue, she was "managing well with baby care and care of the other children."



After being stabbed and bitten by her boyfriend in early 1979, Mrs. McShane was given penicillin and Percodan.

In October 1979, an anonymous phone call was received by social service alleging that Mrs. McShane and her boyfriend were abusing the children. A review of the medical records revealed several possible suspicious injuries to the children and chronic wife battering. In an interview with Mrs. McShane, however, the social worker concluded:

She is reliable and did not abuse the children. (They were present and the relationship seemed good.) Her lover had beaten her on several occasions but has recently discontinued abusing her after she stabbed him. She does not seem to believe that past episodes of battering are matters of current concern.

Two days after this investigation for possible child abuse, her boyfriend, whom she had left, beat her with a pipe. She defended herself by throwing hot water at him. Her physical appearance was described as "appalling." She was diagnosed a "battered woman," referred to social services, and her injuries were photographed by the police. Nevertheless, she was refused admission to the hospital because "there are no medical complications." In contrast, her boyfriend was admitted "because there is no one at home to care for him." In further contrast, Mrs. McShane was arrested.

A year later, she presented four months' pregnant, after her boyfriend (of seven years) beat her with a hose. The psychiatric note describing the incident reads in part:

Patient and her boyfriend of seven years have long history of physical violence toward each other resulting at various times in hospitalization for trauma. Yesterday, patient and boyfriend got into a fight. Boyfriend stated that patient threw the baby out the window. Protective services took custody of the five children. Patient and boyfriend continued to fight. Patient threw a brick at the boyfriend and she was arrested. Later, the boyfriend was shot four times. Patient does not remember what happened. She states she didn't have a gun and there was a lot of noise outside. Patient is obviously quite confused about this. Currently the boyfriend is in the intensive care unit. Patient was committed to the——Hospital.

During her stay at the state mental hospital, the boyfriend died. The social worker reported, "Her life has been involved with a boyfriend



who had inflicted very harsh, extensive physical abuse on her. She is passive, withdrawn with a history of depression and suicidal ideation."

### *Case Analysis*

Mrs. McShane entered our caseload in 1981, almost four years to the day after her first hospital visit for trauma due to abuse. She had just delivered her sixth child. The child was identified as at risk for abuse "because of the long history of physical abuse of the mother." For the same reason, notes the record, "the other sibs are in foster homes." The social worker in the women's clinic detects no sign of current abuse, but does remark that Mrs. McShane has a "nervous condition" and that, a year previously, she was referred to a hospital-based battered women's group, but failed to keep her appointments. Her current therapist reiterates the earlier observation that she is passive, withdrawn, and describes herself as depressed.

To her clinicians, Mrs. McShane presents a classic profile of progressive psychiatric deterioration brought on by a multiproblem childhood characterized by alcoholic and abusive parenting. However, recognizing her as a battered woman suffering from the dual trauma of violence and institutional victimization helps us appreciate the "iatrogenic" (hospital-induced) basis for her problems.

Although Mrs. McShane is no longer in an abusive relationship, she is still entrapped in the psychological status constructed around her dual victimization. The first step to relieving this status is to determine the extent to which her post-traumatic responses are rooted in past violence and in help seeking. The relative sympathy Mrs. McShane received when her abuse was first recognized contrasts markedly with her stereotypic and impersonal reception just five years later. How hard it is for psychiatry and social service to see that this "depressed" and potentially suicidal woman, who appears passive and withdrawn, is the same "reliable" mother whose persistent and courageous effort to get help was once so admirable and to understand that those who now pity Mrs. McShane have contributed to her transformation from abused woman to battered victim.

The sheer accumulation of one woman's pain and suffering in medicine's presence is startling. The boyfriend is "brutal." Mrs. McShane is "overwhelmed with problems," frequent and severe injuries, multiple unwanted births, and children placed at risk by the boyfriend's violence. Yet, it is precisely these obvious and uncontroversial qualities of Mrs. McShane's story—the tragic aura that surrounds her life—that must be



penetrated. Her appearance as a pathetic victim of battering is as much consequence as cause of the way in which her experience is constructed as tragic. Unlike Mrs. Smith, Mrs. McShane is seen as a "battered woman." Nevertheless, like Mrs. Smith, the way she is seen so obscures her situation that the violence ("beat up by boyfriend") appears part of her condition rather than as a discrete act(s) for which someone else is responsible. To bring the violence back into the foreground, her experience must be viewed through the prism of her struggle for autonomy. So long as she is known as helpless, she cannot be helped.

A number of factors enter this complicated case. We see classic indicators of battering, including multiple, frequent, and centrally located injuries of varying severity, injury during pregnancy, multiple unwanted births, building anxiety around medical visits, suicidal ideation, and increasing "silence" in the face of medical indifference. Early medical visits are characterized by neglect. For instance, a note that she was injured after being "hit by fists" is only meant to determine what sort of workup she requires, not to identify who wielded "the fists." Her injuries are subsequently traced to physical abuse and some effort is made to locate appropriate resources. Still, the overall medical response makes it likely that the outcome would have been the same even had a battered women's shelter existed in the community in 1977, as it does today.

Mrs. McShane consistently cares for and is concerned about her children. Despite the fact that she is allegedly "overwhelmed with problems," after the birth of her fourth child she is found to be "managing well with baby care and care of the other children." Her investigation for child abuse a year later finds her "reliable," nonabusive and to have a "good" relationship with the children. Why, then, does the record note a "history of child abuse" when she presents with abuse-related injuries just two days after this investigation? During a particularly intense "fight," protective services temporarily remove the children. But this is motivated not by the unsubstantiated claim that she "threw the baby out the window," but by the "long history of physical abuse of the mother." The seeming paradox—she is a good mother and her children are abused—reflects the fact that her boyfriend is abusing the children, not her. Ironically, the five children are placed in foster care shortly after she kills the boyfriend, thus eliminating the major threat to her children's safety. She is punished for her victimization by having her children taken away.

The sexist bias might be emphasized. She is held "responsible" when her boyfriend abuses the children, but nothing is done to sanction his



violence. And although her subjectivity as a mother is repeatedly acknowledged, no thought is given to her capacity to select relevant options for herself. The boyfriend, not Mrs. McShane, is admitted to the hospital. She is arrested, not he. She is sent home with both hands bandaged to provide child care (her work). But he is hospitalized with relatively minor problems "because there is no one at home to care for him." Racial prejudice is also a factor, particularly in the referrals to family services (rather than at the more prestigious community mental health center) and the repeated implication that violence may be "normal" for such women.

The clinical response directly contributes to her passivity, her mounting rage, and any growing resentment Mrs. McShane feels toward her children. As isolated injuries mount despite symptomatic treatment, clinicians project their failings onto Mrs. McShane and then treat them as hers. Again, a response that begins with pain medication and minor tranquilizers proceeds through stereotypic labels and punitive interventions, including removal of her children. She attempts to abort her fourth pregnancy, but her physician tells her the baby has died in utero. When the mistake is revealed too late to abort, her appropriate anxiety that the baby may be "abnormal" due to arrested growth and beatings during pregnancy and the fact that "she did not want this child" (again appropriate given the beatings) are presented as internal evidence that she needs psychiatric hospitalization. On another occasion, when she extends a request to be placed in the community mental health center to "any hospital," she is denied the treatment and security hospitalization might afford. In addition to repeatedly demanding psychiatric care, leaving her boyfriend, calling the police, moving in with her sister, managing the care of five children, she fights against, stabs, and finally kills her boyfriend. Yet she is seen—and treated—as lacking all capacity for initiative.

We meet Mrs. McShane "overwhelmed" with multiple problems, many the direct consequence of ongoing abuse, entrapment, and institutional neglect. But these problems are portrayed (and experienced) as the context that makes abuse inevitable and explains her alleged personality deficits.

At her third visit to the hospital, Mrs. McShane is referred to psychiatry. For whatever reason, the psychiatrist refers Mrs. McShane to family counseling and then sends her home. When she returns "with both hands splinted" and convinces the social worker she "cannot care for her children," she is given a bed overnight for "rest and care and help with the social situation." This visit was prompted because her



boyfriend beat her severely with a club, dislocating her thumb. Although the social worker is candid and sympathetic, her note makes no mention of serious injuries, lists the primary presentation as "nervous" and the diagnosis as "postpartum depression."

Abstracting the fact that Mrs. McShane "feels too nervous to go home" from the danger awaiting her there effectively decontextualizes her fear. When she kills her boyfriend several years later, nervousness has evolved into a "nervous condition," an independent problem that continues even after the boyfriend's death. And this condition reflects her underlying psychiatric problem, "postpartum depression." This primary diagnosis is further supported by her "worries throughout her pregnancy" that her child will be malformed, worries that are partly iatrogenic and partly reflect the situation at home. By referring to her last pregnancy euphemistically as "stormy," the social worker reintroduces physical abuse as a mere background factor for the real problem, the depression. Allegedly, a "stormy" relationship during the previous pregnancy evokes fears about the newborn's safety during this one because the depression is chronic.

In the context of her depression, the violence becomes a "problematic relationship" with the boyfriend. Then, this difficulty in relating, like the underlying depression, is explained by the patient's history. A broken home, cruel foster care, a natural father who first rejected her and then beat her, and paternal alcoholism have all conspired to evoke her current difficulties. Indeed, the picture that emerges from this history of a multiproblem family is so complex that the main feature of Mrs. McShane's existential predicament, the determining feature of her "nerves" and arguably the only feature about which anything substantial can be done—her battering—is concealed. Alongside childhood abuse, abandonment, and paternal alcoholism, her "problematic" relation with her boyfriend seems tragic but natural, the virtually inevitable culmination of her history. This is hardly the point where intervention should begin. Psychiatric hospitalization is recommended not to protect her from the problem the family is for her, as she demands, but to exorcise the family inside her, the lived memory of childhood pain which is presumably reproduced in her "problematic" relationships.

Thus, even as Mrs. McShane's problems are viewed holistically, they are overcontextualized. However important child abuse, abandonment, or paternal alcoholism may be in her life, their recitation in response to her help seeking, "overwhelms" her current predicament, making it opaque. Sensing this, she refuses to focus on past events. When abuse by a previous lover is offered to explain her current beatings, she insists



that past abuse is "not a matter of current concern." Although the hospital will not even deal with her immediate problem, her reluctance to deal with her past is presented to show she lacks credibility as a witness to her own experience.

Mrs. McShane's survival efforts border on the heroic. She fights her boyfriend, talks about her problem, with anyone who will listen, defends her children, stabs her assailant twice, throws him out, separates; moves in with her sister, and calls the police. The label of "depression" sticks, however, and combines with other aspects of the treatment process to help make Mrs. McShane the "victim of circumstances" she is supposed to have been from the start.

When we meet Mrs. McShane, the opacity of her social situation to her helpers has been transferred to her. It is she, not her clinicians, who fails to recognize what is real. She is unresponsive, not the institution. Where once she was sent home almost mummified ("with both hands splinted"), where she was refused a bed although her injuries were "appalling," it is Mrs. McShane who is now described as "passive and withdrawn," not the hospital. The woman whose abuse was lost in a maze of clinical jargon (literally overwhelmed by diagnoses) comes to us "overwhelmed" with problems, a stereotypic victim of battering.

However, even with her confidence and autonomy undermined, her behavior remains strategic, particularly vis-à-vis the threat at home. With her options foreclosed, she kills her boyfriend, then claims to be "confused" about what happened, a mental state fully consistent with her "nervous condition." Now, she is given the psychiatric hospitalization she has sought. Her abuse is done and she bears the sixth child without fear of reprisal from her lover. Still, just four years since she appeared at the hospital, she has lost five children, inherited a nervous condition, and has a murder case pending in superior court.

## TOWARD A POSITIVE THERAPY: RESTORING PERSONAL POWER

### *Therapeutic Goals: Autonomy and Empowerment*

Institutional victimization combines with interpersonal violence to transform persistent, assertive women into "helpless victims" for whom "nothing can be done." Our therapeutic goal is to restore autonomy, by which we mean a sense of separateness, flexibility, and self-pos-



session sufficient to define one's self-interest in both interpersonal and public contexts and make significant choices about present behavior and future courses of action.

As Hare-Mustin and Marecek (1986) point out, as a psychological goal autonomy may conflict with another important therapeutic principle, "beneficence," the desire to serve the patient's welfare by getting her to make the "right" or "healthy" choice. To a degree, all therapeutic encounters pose the dilemma of supporting independence through a benign dependence. But this beneficence must be carefully managed with women who alternately feign dependence (as a means of survival), fear it (because it has put them at risk), and experience it as the antithesis of genuine integrity. Nothing feels more like failure than when an abused woman returns to—or refuses to leave—a violent relationship. But in trying to rescue such women, we inevitably reinforce their sense of not being able to do for themselves. When benign paternalism fails, therapists often behave like rejected lovers and may identify with the assailant's anger.

But autonomy is a transactional rather than an exclusively individual capability. Independence and separateness are functions of situations that offer the space and resources for genuine self-development. A woman's power to make independent choices depends on how authority is structured around her. Accordingly, treatment must extend to the realignment and exercise of power in the home and helping environment.

As a social goal, autonomy for women raises a range of issues about personal and professional loyalties which are more easily resolved in the abstract than in practice. As the scope and consequence of institutional maltreatment become clearer, an advocacy-coaching model of intervention comes to the fore in which the therapist's knowledge of systems can be put to work. Here too, however, a thin line separates support from rescue. For example, while it is important to help a woman separate the real denial of resources to which she is entitled from feelings of powerlessness evoked by the violent relationship, it is also possible to reinforce her sense of powerlessness by blaming "the system" for everything. In the role of advocate, the therapist may collude in strategies to circumvent barriers to help. But this must be done without increasing the client's subsequent vulnerability.

### *The Therapist and the Battered Women's Shelter*

The dual trauma of battering must be countered by a dual strategy of empowerment; shelter (or social support) to change the context of



unequal power in which battering develops, and therapy (or support for individual autonomy) to help the woman take full advantage of her options. Shelters help women regain much of their strength and confidence because, in addition to offering personal support against abuse, they resituate women politically vis-à-vis the helping services. Post-traumatic therapy evokes a parallel process that works best in community-based facilities with ongoing liaison to shelters, courts, police, and health services. One difference is that where shelters depend on collectivity and mutual recognition, the therapist mines the substructure of a woman's battering experience to recover a more individualized sense of possibility. The convergence of mutual support with individual autonomy is what we mean by empowerment.

Within the context of the shelter, strengthening a woman's bonds to other women in similar circumstances becomes an effective way to elicit resources from the helping system. But most abused women do not enter shelters, and even those who do must return to the world they have temporarily left. One way to sustain the dual nature of empowerment while avoiding some of the pitfalls of individual advocacy is to simulate (or extend) the shelter experience by opening up a similarly supportive political space either within a woman's network of friends, family, and kin and/or through peer groups of abused women in clinics, hospitals, private practice, or community-based organizations. Psychological and social isolation are both cause and consequence of abuse and institutional victimization. Yet the abused woman's experience is often symptomatic of more generic female experiences in particular neighborhoods, towns, ethnic groups, or extended-kin networks. Social connectedness will not correct an inappropriate professional response. But skillful network intervention which mobilizes indigenous female prowess in the face of anticipated violence, negotiates alignments with supportive males, and establishes formal communication mechanisms linking the most vulnerable to the most supportive can create a milieu in which autonomy and caretaking are mutually reinforcing.

### *Expunging Institutional Victimization*

David Cooper (1971) describes the basic problem in psychotherapy as "progressive depopulation," helping the vast family that patients bring with them to "leave the room." In post-traumatic therapy with victims of battering, the bits and fragments of institutional maltreatment that have accumulated in the patient's psyche over the years must be exorcised before a less dysfunctional relation to caretaking can develop. Whatever else it may be, battering is a story that must be told and



heard. Eliciting a history of previous trauma (the trauma history) is the first step in patient screening, identification, and assessment. Equally important is the history of institutional care. Just as we must help patients in other circumstances differentiate their own stories from those that have been projected onto them by significant others who threaten to withhold love, so is the history of help seeking elicited from abused women to help them differentiate appropriate help-seeking behavior from the multiple interpretations that have been driven home through the withholding of resources by professionals. In some sense, the history of help seeking serves as counterpoint to the trauma history, helping the woman to recover a sense of self she can recognize as uniquely hers, a bounded and credible entity that has carried her purposes into the world even at those moments when she was most oppressed.

One of the more insidious effects of the helping experience is to convince women they are unable to help themselves. Assisting women in recognizing their initiative and supporting their anger at inappropriate institutional responses are essential. However, if they lack direct experience with the social services, middle-class therapists may be naive about their responsiveness and, as a result, disbelieve a client's account or misread her reluctance not to seek further help.

Dorothy Rapp is a New Jersey housewife acquitted for killing her husband because of battering. Mrs. Rapp repeatedly turned to police, neighbors, family, and doctors (PBS, 1985).

*Mrs. Rapp:* I asked the police, "Well can't you take me somewhere?" and they said no. I said, "Can't you arrest him because he's hurting me?" and they said, "Only if you come down and sign a complaint."

*Interviewer:* [almost as if she has internalized the expectation that abused women don't tell]: And you didn't want to do that?

*Mrs. Rapp:* No, because I had done it before, I had signed a complaint. . . .

By contrast, clients may not recognize what middle-class professionals take for granted, that services can be made to work for them when the political conditions are right.

As abuse becomes battering, a woman may discover she has exhausted her "social margins," the formal and informal sources of support she has turned to in the past. Now, efforts to get help give way to plans for escape, then for bare survival. Although the desire for independence remains, it is expressed negatively, as a stubborn refusal to yield to domination.



Mrs. Rapp: He put the shotgun right there [gesturing to her head] and said, "I'm going to do it." I said [lifting her head challengingly], "Go ahead. What are you waiting for?"

Interviewer: Did you mean that?

Mrs. Rapp: You bet I did.

Though a listener senses the element of resistance, Mrs. Rapp is confused about who is responsible for the abuse. She interprets her story as a tale of failure and dependence. Later in the evening, her husband goes outside, promising to shoot her when he returns.

Mrs. Rapp: I lay there thinking, "I deserve this because I'm bad. . . . I mean he kept telling me I'm bad."

And, later, as if she has forgotten her years of frustrated help seeking:

Mrs. Rapp: I thought I deserved it. So I didn't do anything to get help. I guess I really loved him.

Mrs. Rapp's decision to kill her husband might be interpreted as an "instinct for survival." The traumatization framework, in contrast, locates her "outburst" on a logical continuum with her persistent (and frustrated) help seeking and her stubborn resistance and approaches her apparent dependence as ambivalence toward her underlying anger and assertiveness, rather than their negation. Counterposing Mrs. Rapp's actual behavior (e.g., her persistent help seeking) to her negative self-image highlights the "gap" created by victimization and builds on the rational core of autonomous behavior without minimizing victimization and vulnerability.

### *Identifying the Politics of Personal Independence*

The normally difficult task of disentangling the effects of violence from institutional victimization are compounded if the therapist is uncomfortable with female autonomy. The persistence and stubbornness exhibited by Mrs. McShane and Dorothy Rapp are rooted in the politics of personal independence. Even in the most unequal, pitifully traditional or circumscribed relationships, battered women experience abuse and institutional victimization as part of a gender-based struggle over personal integrity and situational control.

Sometimes, the risks and terms of conflict are explicitly calculated.



In one client's words: "It was a second marriage for us both. We pooled our savings to buy a condo. I knew there would be a power struggle. I just didn't expect the violence." But more often, the initial conflict over female independence has become enmeshed in—and must therefore be retrieved from—a mire of secondary problems, such as his drinking (or hers), which now dominate abusive episodes. To the abused woman, the restriction of autonomy is as important as the violence. Though a truckdriver beat his wife whenever he returned from a long-distance haul, their final break occurred when he refused to let her attend church. And it was when she was forced to burn her school books that Francine killed Micky Hughes. Identifying this moment of autonomy within the experience of subordination and abuse and linking it to the history of aggressiveness and persistence are crucial steps in a positive therapy.

### *The Interactive Element*

When a woman has identified her personal agenda, it is possible to confront the interactive element in battering without blaming the victim. In its emphasis on the gender-specific character of abuse, feminist theory justifiably downplays this aspect. In fact, however, as Mrs. Rapp's challenge to her husband illustrates, abused women repeatedly engage their assailants, seek to control their situations even under the severest constraints, are often quite direct about their needs, and, as we have seen, are persistent and strategic in their help seeking. The typical battered woman is not a feminist in any programmatic sense and may even swear allegiance to a traditional role. Nevertheless, she and the assailant are well aware that conventional role behavior is not meeting her needs and that her behavior—or the meaning she secretly attaches to it—contradicts her expressed sense of how she should behave. The refusal of traditional responsibilities assigned to women—such as housework, child care, or meeting a man's sexual needs—is a common context for abuse. For such a woman, it is far more useful to normalize the actual behavior in the relationship (e.g., "no one likes to cook or clean") than to try to reconcile her behavior and her expressed conception of femininity with reassurances that "she is a good housewife and mother" (e.g., she may not be).

The batterer may see the relationship as a zero-sum game in which each sign of a woman's separateness represents something taken from him or, alternately, a failure in his ability to provide. She may have recognized the relationship is limited and sought to meet her needs elsewhere, through a job, school, friends, or a lover, for instance. But



his reading of such behavior as betrayal severely constrains her mobility and forces her to increasingly bring her needs home and concentrate what might otherwise be a diffuse quest for self-expression in an aggressive posture which alternates between demand, defiance, and passivity, all acted out within and against the traditional gender role behavior he demands. Uncomfortable with her aggressiveness but equally threatened by the loss of control implied by her autonomy, he tries to enforce a status quo in which she agrees to only present him with problems (or needs) he can solve. This implicit contract, in which couples' therapists often collude, is repeatedly broken by the myriad disappointments of everyday life—a china bowl given by his mother breaks, the baby cries, or the phone rings during sexual intercourse—or by periodic violation of his pitifully narrow boundaries ("I wanted her to push my button"). Requests that he recognize feelings other than anger or sex reawaken his sense of inadequacy and are quickly followed by dependence, fear of abandonment, and fury.

*Mrs. Rapp:* I said, "Gee isn't that a beautiful blue sky and it's so pretty today." And he just hauled off and knocked every one of my teeth out.

Behind his rigid character armor, a physically imposing abuser may imagine his body as tiny and distorted, a self-image that is linked to a tendency for batterers to minimize their violence and shirk responsibility for the pain they inflict. This pattern is also expressed in a Jeckyl-Hyde syndrome where the assailant becomes overly solicitous after a violent episode. Many victims appear tentative in their help-seeking in this so-called "honeymoon phase," though this is less often because they are fooled than because they expect his patronizing dominance to be positively sanctioned by third parties, including friends and helpers. Early intervention can often stop physical abuse. But changing a man's felt need for control is a long-term process. Yet to the abused woman, the issue is the man's control over her, not over his feelings.

### *Victim Investment: Two Approaches*

As their interaction with the abuser becomes isolated and enclosed, abused women may become invested in this "normal" pattern of male behavior. Again, critical examination of this investment process must not lose sight of its positive core.



Where possible, we should build on the limited control women are already exercising in contexts that allow for little or no control. As the abusive relationship evolves into entrapment, control at home, like control in the helping system, is sought indirectly, through somatization (e.g., overweight, excessive fatigue) or through externally submissive, passive, and dependent behavior. Self-blame is commonly read as a signal of the victim's helplessness. However, in battering relationships, it is also strategic, a way of taking responsibility within a limited field, of saying, "I called the police. It didn't work. Next time I'll try something else." When Dorothy Rapp thinks, "I deserve it," she is really framing a set of tactical questions to herself that open a space for action. She considers whether she "deserves it" because "I'm bad" (as her husband claims) or because she is passively waiting to be killed. Thus, it is through self-blame (control in the context of no control) that she acts decisively.

Dependent behavior is also infused with aggressive content and strategic purpose. According to psychoanalytically oriented feminists, such as Chodorow, Dinnerstein, or Gilligan, women's character structure leads them to make sense out of violence by incorporating it into their larger interpretation of the world. According to "dependency theory," women are taught to get their dependency needs met through caretaking, and their displays of passive dependency have a protective and systems-maintaining function for significant others. The therapist may emphasize the man's cruelty. But the victim feels a compulsion to be available for this "fragile" man and becomes invested in his overcompensatory behavior because it reveals his need for caretaking (and so for her).

We cannot resolve the question of whether the apparent "normalization" of violence by certain abused women reflects female character and socialization—as dependency theorists contend—or the situationally specific convergence of systemic maltreatment, interpersonal violence, and strategic dependence—as the traumatization framework proposes. We only want to highlight that an impulse toward personal power and autonomy is often hidden behind what appears to be a self-destructive investment in dependence. As the woman's efforts at supplementing the relationship are disallowed, she is forced to seek her independence within the context of this primary dependence, infusing it with aggressiveness. This feeling is hard to disentangle from the mounting anger she feels toward her assailant (and her helpers). Often, abused women interpret the violence—correctly in our view—as a response both to overt acts of independence and to the impulse toward inde-



pendence concealed beneath a pseudodependent posture. At first, it seems strange or self-effacing to hear a woman we regard as overly traditional suggest, "I deserved it." However dysfunctional, the violence may have become the only reminder she has of the impulse to autonomy that has been quashed by men she regards as emotionally limited. Dependency theory relies on the adherence of victims to traditional female roles and values. Oddly, among abused women, dependence (her underfunctioning) takes on an almost stylized quality behind which a woman has often become increasingly self-sufficient, less respectful of conventional roles, and, as a result, open to personal change. The price she pays is enormous by any standards. But it is a price we must respect.

In situations where dependency theory is applicable, the therapist works to change the conception of a family system so that the woman no longer feels compelled to underfunction in order to support the pseudofunctioning of the male. But for the many women for whom a strategic conception seems more appropriate, the task is to elicit elements in the rationalization of the violence which express an aggressive personality development process. The key here is to distinguish between the passive-dependent behavior that women frequently display, if not cultivate, and the actual level of autonomy and differentiation of self that they have achieved beneath, through, and despite this display.

The strategic substructure of a victim's behavior is not always easy to elicit. As victim's internalize the punitive response to their self-development, they become ambivalent and confused about autonomy and may even, though only under the harshest of circumstances, identify their power through the violence rather than with the independent impulse to which it responds. Moreover, though giving up the violent relationship may be the therapist's measure of success, the victim may conceive of her endurance and struggle as an important phase in her self-development. "After all," she may think in deciding whether to stay, "how many men would let me go even this far?" Whatever we may feel about her choice, if, instead of emphasizing her personal aims, we locate her experience on a continuum extending from dependence to total subjugation, we risk extending her ambivalence into a sustained depression. For many abused women, the psychological alternative to strategic dependence is not dependence pure and simple but the "hom-icidal rage" with which Mrs. McShane, Dorothy Rapp, and Francine Hughes strike out against their assailants. The subordination that results from the dual trauma of battering is a contradictory process that must not be mistaken for submissiveness.



### *The Victim-Therapist Relation*

The therapeutic response must be carefully attuned to the complex profile the abused woman presents of dependence and autonomy, power and vulnerability, ambivalence toward conventional roles and a fear of punishment if she changes. To reiterate, violence and institutional maltreatment establish an unconscious association of autonomy and personal authority with disloyalty, betrayal, and loss. As a result, the abuse victim repeatedly tests the degree to which we choose to see her as dependent and dysfunctional or are comfortable with her competence and autonomy. The history of violence and institutional maltreatment makes battered women hypersensitive to subtle messages that they are "bad" (or "mad") which undermine repeated explicit offers of support. The challenge is to admit an individual and interactive element in battering without blaming the abused woman, to recognize the seriousness of violence without compromising personal issues for family peace, and to establish a sense of current options while remaining respectful and emotionally unreactive to the woman's choice to change or not to change her living situation.

Letting the battered woman know she has done the right thing in talking to you and has behaved rationally within her constraints invokes her strategic capacity in the current crisis. She did not need saving before; she does not need it now. What we communicate about behavior appropriate to women is equally important. In her experience, the pursuit of autonomy precipitates anger and violence from loved ones and service providers. When the abused woman presents herself as powerless, even "passive," she is testing our response as well as expressing her real situation. The victim's dilemma—she must choose between being compliant and loved or independent and abused—converges with our own conflict between beneficent caretaking and support for female autonomy.

Unfortunately despite two decades of rhetoric about helping people "get in touch with their feelings," most therapists still identify more readily with vulnerability, depression, and low self-esteem than with appropriate aggression, particularly among women. Another problem involves a common fear of strong women and a corresponding tendency to project a male stereotype of how women should be (dependent, helpless) through an exaggerated emphasis on our professional role as helpers. Lerner (1984) sees the projected stereotype as a way to devalue the omnipotence of the maternal figure by inverting the therapist's relation to her and treating the patient like a little girl. Regardless of whether we accept this compelling interpretation, the fact remains that



therapists typically value autonomy more highly than dependence or caretaking—and as more healthy—while, at the same time, treating it as somewhat abnormal for a woman to be fiercely independent, to behave strategically, or to seek separateness. The result is that the victim is put in the same double-bind during treatment that she experiences at home. She will get approval only if she behaves in a relatively dysfunctional and ultimately unsatisfying way.

Carmen (Hilberman) et al. (1984a) highlight a related issue. For disorders that are incongruent with society's idealized image of women, such as alcoholism and illicit drug abuse, women's service needs have been hidden and ignored. We have shown that women who experience these disorders as sequelae of abuse are seen as "bad" as well as "mad," hence not as credible victims deserving help. Bograd (1986) argues that the projection of a female stereotype in therapy is linked to the use of *quid pro quo* behavioral contracts in which the husband promises to control his temper for his wife and she agrees to comply with some of his requests. As frequently, the couple agrees that the violence must stop, and the woman accepts certain limits and supplements the relationship. Even if such contracts were not ethically suspect, the compulsive exclusivity that characterizes abusive relationships makes them untenable. In any case, as Bograd insists, separating the couple is a legitimate family therapy move and gives a powerful metastatement about responsibility. Whatever we may think of the incompatibility of independence with violence, no matter how pitiable a woman seems when she says, "I just want the violence to stop," it is not our role to help compromise her political goals. Physical safety is the prerogative of every woman, not something for which she should have to bargain.

Few therapists are fully in touch with their own aggression and so have trouble supporting aggression in abused women. A common tendency is to displace aggressive feelings before they surface, supporting a woman's "insight" that "I'm hurt, not angry," for example, or "I'm not enraged at you, I'm depressed at myself." As serious, many therapists share the batterer's inability to differentiate aggression (which is need centered) from hostility, anger, and violence (where the primary impulse is destructive) and mistakenly conclude that if a woman is aggressive, e.g., if she "fights" for what she wants in a way that infringes on another's space, then abuse is the result of "mutual combat." Disclosing our own difficulty with aggressive feelings helps resolve some of this confusion.

We have viewed woman battering from the vantage of one issue primarily: how the professional response impinges on, enters, and shapes



violent relationships so that struggles for independence that have been met by abusive assault end in "battering," the subordination of women's capacity for social and psychological autonomy. The battered woman can be treated clinically, particularly when intervention includes advocacy directed at changing the system. But ending battering is a political process that entails public recognition of the hazards to self and others represented by the normal male role. Once we have adequately provided for the safety and autonomy of women and others put at risk by violent men, the next step is to close the gender gap that is currently reflected in a paucity of alternatives for men as much as by the institutional victimization of women.

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## *Rape Trauma and Treatment of the Victim*

CAROL R. HARTMAN and ANN WOLBERT BURGESS

One fall evening, the following interaction was observed by a nurse making a home visit to a family who lived in an urban, racially mixed neighborhood. Present were Mrs. A., one daughter, and her husband. Jim, the 14-year-old son, was en route to a store a block away from the house. Suddenly the front door burst open. Jim, distraught and crying, said a gang of young men had jumped him in the street. At knife point they threatened to beat him, stab him, and rape him if he did not give them what they wanted. In great fear, Jim handed over the bag of groceries he was carrying. He managed to free himself, wrenching loose a pocket in his flight.

As he blurted out his story to his agitated mother, father, and sister, they encircled him and in unison began screeching and yelling, "You stupid boy, you retard. You never pay attention . . . didn't you look back of you . . . you slow . . . lucky they didn't rape you or do more to you . . . stick a knife in you. You don't pay attention; that's how come it happened. . . ." All the while these things were being said, the family members walked back and forth, pointing fingers at Jim, who stood wide eyed and crying, backed against the kitchen wall. The family's response was startling, but more puzzling was the fact that it all seemed appropriate to Jim. Gradually it became clear that the seeming criticism was not really anger, but rather deeply felt concern and fright. The nurse commented that Jim could not follow all the advice they were trying to give him. The outburst quieted the family members somewhat, but they continued blaming Jim and telling him how to



behave on the street. Eventually, they each recounted personal frightening moments and told Jim how their individual alertness had protected them.

This example of a victim and his family reaction illustrates the complex social pattern of expected personal responsibility. This responsibility is to be understood as germane to coping and surviving in an unpredictable social environment. In the example, the family was unaware of their level of agitation and their hysterical excitement. For a moment in their imaginations, each was both the victim and the victimizer. They identified with Jim, but identification was overshadowed by their blaming behavior. This phenomenon manifests itself in more sophisticated ways among the educated. Often in cases of sexual trauma involving rape, incest, and spouse abuse, the victims are told that they, to some degree, are responsible for being victims. This chapter presents clinical cases with the intent to prompt dialogue among clinicians regarding the issue of blame and victimization.

In the United States rape affects the lives of thousands of people each year. The Uniform Crime Report indicates over a 100% increase in reported forcible rape cases between 1970 (over 37,000 cases) and 1979 (over 75,000 cases). The Uniform Crime Report (U.S. Department of Justice, 1986) states there was a 3% increase in all offenses (p. 163). Forcible rapes, that is, carnal knowledge of a female, forcibly and against her will, were estimated in 1985 to be 87,340 or 36.6 forcible rapes per 100,000 population. This figure comprises 7% of the violent crime volume and 1% of the Crime Index (p. 14). In addition to these estimates, there were 86,861 *arrests* for sex offenses (these exclude arrests for forcible rapes and prostitution) or 42.8 offenses per 100,000 population for the year 1985 (p. 165). This later figure addresses, in part, the sexual exploitation of people regardless of gender or age.

There are new findings on the subject of hidden rape. Mary Koss, studying the incidence and prevalence of sexual aggression and victimization on college campuses, argues that because of the inadequacies in the methods used to measure sexual assault, national crime statistics, criminal victimization studies, and conviction or incarceration rates fail to reflect the true scope of rape. Studies that have avoided the limitations of these methods have revealed very high rates of overt rape and lesser degrees of sexual aggression. However, the researchers continue, existing research has been based on samples of limited generalizability. In Koss' study (1985) the Sexual Experiences Survey was administered to a national sample of 6,159 women and men enrolled in 32 institutions representative of the diversity of higher-education settings across the



United States. College students were studied because they include 25% of the civilian population aged 18 to 24, the age group with the highest risk of rape. Women's reports of experiencing and men's reports of perpetrating rape, attempted rape, sexual coercion, and sexual contact were obtained, including both the rates of prevalence since age 14 and the rates of incidence during the previous year. The findings support published assertions of high rates of "hidden rape" and other forms of sexual aggression among large normal populations such as college students. The results challenge myths that acts of sexual aggression are heinous, but rare events. Instead, the potential for sexual aggression and victimization appears to be significant and real in the lives of young people. The results indicated that 15.4% of college women reported experiencing and 4.4% of college men reported perpetrating since the age of 14 an act that met strict legal definitions of rape. An additional 12.1% of women reported experiencing and 3.3% of college men reported perpetrating an act that met legal definitions of attempted rape. Thus, a total of 27.5% of college women were victims of rape or attempted rape and 7.7% of college men had perpetrated these sexually aggressive acts. Virtually none of the rape victims or perpetrators had been involved in the criminal justice system. Thus, these young people's experiences qualify as "hidden rape" and their response pattern as silent reaction to rape trauma.

Historically, the realization of rape as a violent act committed in a sexual context signaled the beginning of national efforts to address the problems inherent in this traumatic life event (Largen, 1985). Prior to the resurgence of the women's movement, avoidance and silence dominated the professional reactions to victims of rape. Given this pattern, the first efforts of feminist women's groups and professionals were to raise awareness of others that rape was a criminal act not desired by the victim. Furthermore, the victim was not responsible for the behavior and choices of the predator. The rapist was acting out of his own intentions and patterns of beliefs. Previously, the act of rape and victim response was strongly linked to the social discrimination and oppression surrounding the sex role attributes ascribed to women, such as, "If you flirt you deserve what you get." Much of the recent reporting and writing on the subject has been to stop discriminatory attitudes toward women and their sexuality. Consequently, there has been a concerted effort not to link responsibility to the rape victim. Feminists have emphasized how blaming women for rape has been a strategy employed to keep women fearful, helpless, and under control (Brownmiller, 1975). These efforts to understand rape as an aggressive as well as a sexual



act has had both a negative and a positive consequence on investigation of the phenomenon. The negative result is a bias against understanding the prior characteristics of the victim and their influence on recovery from rape because past efforts of psychological inquiry placed blame on the victim. The positive aspect of focusing on the event itself has given insight into the power of the event in disorganizing behavior and in the processes of reintegrating the realities of the event over time. In addition, the event and its reintegration are now more likely to be understood within a social context of the family, public, and judicial system.

The need for identifying variables and factors that influence recovery from rape is imperative. A descriptive database is being accumulated which indicates that people who have been raped do not necessarily return to a prerape level of psychological functioning, though there is a return to social role functioning (Burgess & Holmstrom, 1978; Ruch & Leon, 1983; Sales, Baum, & Shore, 1984; Veronen & Kilpatrick, 1983). These findings occur among people who have and have not received crisis intervention and mental health services.

In this chapter we use the clinical case method to address the impact of and recovery from rape. We identify varied response patterns to rape; we offer a scheme of phases for organizing and isolating variables that might have a bearing on recovery.

## PHASES IN THE TREATMENT OF RAPE TRAUMA

The following case example illustrates the sudden, overwhelming, and life-threatening quality unique to blitz rape attacks. Additional information is needed for beginning the assessment process for the crisis response to this victim. This section presents a framework of phases aimed at recovery from rape trauma.

Having made reservations to stay in a national chain hotel, a 32-year-old sales executive entered the hotel garage in her rented car. She was unable to get a ticket from the automatic machine and no one was in the garage booth to give instructions. She continued into the garage and found a parking space on the second level. As she was gathering her belongings to leave her car, she was aware of a man running over to her and thought he had the parking ticket. Suddenly, the man forced a sharp instrument to her neck and a second man



appeared. The woman was thrown into the back seat and abducted from the parking garage.

While in the back seat, the woman tried talking to the men. This met with increased verbal aggression ("Shut up, bitch") and the weapon being jabbed into her ribs. The car subsequently stopped; the victim was blindfolded, forced out of the car, and locked in the trunk of the car. The car continued and stopped several times over a one-to-two-hour period. Finally, the car stopped again. The victim was pulled out of the trunk and shoved back into the car, where she was forcibly raped orally and vaginally by both assailants. She was also forced to drink some type of liquor from a bottle.

The assailants then lectured the victim about keeping the car doors locked as they were going to leave her in a "bad" section of town. They ordered her to count to 10 and they left the car. The victim removed the blindfold, calmed herself as best she could, and began looking for help. She was able to ask someone for directions to a hospital and was led by another car to a hospital.

At the hospital, the victim was seen by various staff members. The police were called, and she gave a statement to two officers. She telephoned her boyfriend and her brother. The brother came to the hospital and took her back to his apartment.

The phases are defined by time: the *pre-trauma phase* includes dynamic and stable factors of the victim's life and personality prior to the assault; the *assault phase* includes the rape and its characteristics, the rapists' interaction with the victim, the victim's survival strategies; the *disclosure phase* includes the response of the health care system, the social network of the victim, and the criminal justice system and how the rape is cognitively and affectively processed by the victim; and the *postdisclosure phase* is concerned with the demand for integration of the rape experience and the consequences of disclosure, organizing a symptom-free state, and planning for the future.

#### *Pre-Trauma Phase*

Two important areas related to the pre-trauma phase of a victim include prior life events and experiences of the victim and personality characteristics. The influence of prior events on recovery is a complex matter. Mastery of prior events may operate to help an individual handle another major stress. Thus, coping behaviors are important to assess.



There are many difficulties in defining what is meant by personality characteristics, as well as in measuring them. Of particular interest is discerning whether an individual has a particular trait (constellation) of cognitive processes for handling new and traumatic information.

### *Traumatic Event Phase*

The critical factors of this phase are the circumstances of the rape, the type of rapist, the interaction between victim and offender, and the coping behaviors employed by the victim.

Type of rape (Burgess & Holmstrom, 1979a) may be blitz or confidence, which suggests a motivational structure and operational plan of the rapist designed to overpower and disrupt the psychological organization of the victim, establishing either a complete state of helplessness or complicity. Blitz rape is an assault that occurs out of the blue and has a sudden, anonymous quality to it. The typical example of blitz rape occurs when a victim crosses the path of the predator who is looking for someone to capture and attack. The confidence-style assailant gains access to the victim under false pretenses by using deceit, then betrayal, and often violence. Characteristically, in this type of rape there is prior acquaintance between the victim and the assailant, however brief. The assailant may know the victim and thus already have developed some kind of relationship with her, or he may establish a nonthreatening interaction as a prelude to attack. The assailant may attempt to offer protection or help, e.g., fixing a tire or offering a ride. The elements of force, conning, and betrayal have specific meanings and may affect the rate and degree of recovery.

Questions related to circumstances of the assault include: When and where was the victim approached; why was the victim there and where did the assault occur; who was the assailant(s); was he of the same race; was he a stranger, acquaintance, or relative of the victim? What conversation occurred; what sexual, aggressive, and/or humiliating remarks were made; what did the victim say? What methods of control were used in the assault; were there threats, weapons, physical force? What types of sexual acts were demanded and obtained; what additional degrading acts were demanded?

*Coping and survival strategies.* We begin a clinical assessment by analyzing how the victim coped with and survived the assault. The coping strategies are useful to assess in order to predict future coping strengths. Coping behavior may change according to the tasks required



in the various phases of the attack. Some victims report an early awareness of danger ("I heard a noise in the kitchen and went to investigate"). The coping task at this phase is to react quickly to the warning. In the next phase—threat of attack—victims realize that there is definite danger to life and the coping task is to try to avoid the danger by various methods, for example, stalling for time, talking, reasoning with the assailant, trying to change his mind, using flattery, bargaining, feigning helplessness, threatening the assailant, and joking and sarcasm (Burgess & Holmstrom, 1976).

Phase two—the attack—occurs when rape is inevitable. The coping task becomes physical and psychological survival. Coping strategies may be cognitive (mentally focusing attention on a specific thought, remaining calm, memorizing details, recalling advice, praying, concentrating); verbal or affective (talking, yelling, screaming, crying); physical (trying to avoid full sexual penetration or getting the assault over with as fast as possible).

The last phase occurs immediately after the rape, and the coping task is to escape from the assailant and seek help. Victims cope by trying to alert others, bargaining for freedom, and physically freeing themselves from the scene and the assailant.

Returning to the case example, the attack was blitz: sudden and with no prior warning. The victim was minding her own business trying to find a parking space in a garage when she was abducted forcibly by two armed men.

The circumstances of the rape and kidnapping include the following: The assailants were strangers and of a different race than the victim. She was asked many questions of a racial and sexual nature and was forced to listen to degrading references to herself. The victim was controlled by two assailants, the use of a weapon, blindfold, and confinement in a car trunk. The victim was forced to have oral and vaginal sexual contact with both assailants and was forced to drink liquor.

The victim tried a variety of coping strategies immediately after being abducted, including talking, crying, and pleading with the assailants; however, this increased their verbal and physical aggression and so she stopped. After she was locked inside the car trunk, she concentrated on thoughts of her family. She had difficulty breathing and lay in fetal position to survive. She was terrified that the liquor had been poisoned and she feared she would be killed.

The victim was free of the assailants when they left the car. She immediately sought assistance and was directed to a hospital.



In completing an initial assessment, the clinician should constantly focus on how the victim *felt* and *thought* about all details of the rape.

### *Disclosure Phase*

The disclosure phase is the period of time when the victim identifies herself or himself as a victim of rape and socially discloses the event. This can be initiated by the victim or others, such as the police or parent coming upon the assault or its aftermath. Important factors in this phase are the reactions of the health care system, the criminal justice system, and the victim's social network.

Clinical studies have stressed that the callousness of the various persons who come in contact with the victim can greatly compromise the victim, exacerbating symptoms. This point is noted in the case example. The following is the victim's account of her experiences with hospital personnel and police.

I ran into the hospital. I had an overwhelming fear that the sadistic one was still there or in the trunk. I wanted to be safe. I went up to the nurse and said I needed help and would she call the police. . . . I had to take off my clothes and sit in a johnny for a long time. I wanted someone there. A police officer came in and asked some cursory questions. I started feeling angry and he left. A nurse came in and asked about my bruises. . . . I thought there might have been poison in the liquor and asked them to test it. They said it was evidence and they couldn't touch it. I thought I could be dying and they will be sending the bottle to the lab. I got really angry. I had been there an hour and a half. I put my pants on and went out to call my brother. . . . They had me talk to another police officer and that went OK. I got in an argument with the hospital and they lectured me. Then I called my boss and he was supportive. I called my boyfriend and that didn't go well. We had broken up the previous week and I wanted him to meet me at the airport. He said he had to do some things and he'd try to pick me up. Then my brother arrived and he was great and we got out of the hospital.

This account illustrates the impact of the various people that the victim has to deal with at a time that she is under great stress and how she perceives their support and assistance. She later learned that her boyfriend, being awakened out of a sound sleep at 4 A.M., did not fully



realize that she said she had been raped until she hung up and thus was unable to be supportive to her on the telephone.

### *Postdisclosure Phase*

Critical factors to be considered during the postdisclosure phase are: crisis intervention and treatment; outcome of the criminal justice system; evaluation of the victim's recovery.

Returning to the case example, the victim was notified by the police about a month later that two suspects had been apprehended. These suspects admitted to the rape as well as other rapes and plea-bargained the charges. It was not necessary for the victim to return to the city for a criminal trial. She also had crisis counseling of several sessions and a series of 12 victim therapy sessions six months after the rape.

## DIAGNOSIS OF SEXUAL TRAUMA

Although the official reporting agencies indicate an increase in reported rape, it should be remembered that not all victims will report a sexual assault. Therefore, clinicians should be alert to situations in which the victim does report immediately and those in which there is a delayed time period. Examples of rape trauma, both immediately reported and not immediately reported, are included in this section.

### *Rape Trauma: Immediate Reports*

The legal definition of rape varies by statute from state to state. The main issues generally addressed in all statutes include: lack of consent, force or threat of force, and sexual penetration by one person not the spouse of the other.

Rape is defined within a humanistic context by psychiatrist Elaine Hilberman (Carmen) (1976), who emphasizes rape as "the ultimate violation of the self, short of homicide, with the invasion of one's inner and most private space, as well as the loss of autonomy and control" (p. X).

The clinical term rape trauma describes a clustering of biopsychosocial and behavioral symptoms exhibited in varying degrees by a victim following a rape. Most victims of forcible rape develop a pattern of moderate to severe symptoms described as rape trauma syndrome; a minority of victims report no or mild symptoms. This syndrome is an



acute reaction to an externally imposed situational crisis (Burgess & Holmstrom, 1974).

There is generally an immediate impact reaction. Victims evidence a wide range of emotions in the hours and days following the rape. The physical and emotional impact may be so intense that the victim feels shock and disbelief.

Two styles of emotion are often noted in victims: expressed and controlled. In the expressed style, the victim demonstrates such feelings as anger, fear, and anxiety. This style is noted by the victim being restless during an interview, becoming tense when certain questions are asked, crying or sobbing when describing specific acts of the assailant, and smiling in an anxious manner when certain issues are stated. In the controlled style, the feelings of the victim are masked or hidden, and a calm, composed, or subdued affect can be noted.

An acute phase of the syndrome includes physical symptoms, especially skeletal muscle tension, gastrointestinal irritability, and genitourinary disturbance. Marked disruption may be noted in eating and sleeping patterns, as well as a wide range of emotional reactions.

The second phase of the syndrome—the reorganization phase—includes increased motor activity. During this phase a search for security necessitates changes in telephone and place of residence. There may be an increased need and request for family and social network support. The development of fears and phobic reactions to the circumstances of the assault are common, as well as repeated frightening and disturbing nightmares.

The trauma of the victim results from the confrontation with a life-threatening and highly stressful situation. The crisis that results when a person is raped is in the service of self-preservation. The victims' reactions to the impending threat to their lives is the nucleus around which an adaptive pattern may be noted.

### *Post-Traumatic Stress Disorder*

The early conceptualizations of the stress response patterns of rape victims (Sutherland & Scherl, 1970; Burgess & Holmstrom, 1974; Symonds, 1975), although not controlled, systematic studies, provided important descriptive information and have prompted subsequent research. Several large-scale studies have been conducted, according to Resnick (1983), that are now yielding surprisingly consistent data. Rape victim responses are consistent with the diagnostic criteria of post-traumatic stress disorder (PTSD) of the DSM-III. The four cardinal criteria are outlined as follows:



1. The stressor must be of significant magnitude to evoke distinguishable symptoms in almost everyone. PTSD is defined by symptoms that have a temporal and presumably causal relationship to a stressor beyond human experience (Ochberg & Fojtik-Stroud, 1984).
2. The victim reexperiences the trauma, which is most frequently evidenced by recurrent and intrusive recollection of the event.
3. There is numbing or responsiveness to or reduced involvement with the environment.
4. Two of the following symptoms are present that were not present prior to the rape: exaggerated startle response or hyperalertness, disturbance in sleep pattern, guilt about surviving or behavior during the rape, impairment of memory and/or power of concentration, avoidance of activities that arouse recollection, and increased symptoms to events that symbolize or resemble the traumatic event.

Returning to the case example, the following stress response pattern was noted. In the acute or disruptive phase, the victim experienced many symptoms. She had difficulty sleeping; she would wake up at night and experience an anxiety attack. Everytime she lay down, she kept recounting the events of the evening of the rape. She would get a visual picture in her mind that created an enormous amount of fear. She kept feeling the presence of the rapists. She was unable to stay alone; she could not tolerate the dark. She could drive in a car only if the doors were locked and the windows closed. She could not watch television programs with violence or read her favorite mystery books. She had difficulty concentrating, and although she returned to work, she was not able to function at her pre-trauma level. Physically she was bruised and sore and her back ached. She did not attend to usual tasks, such as paying bills, and developed a tendency to "let things slide."

The reorganization phase had many symptoms. Although she was able to resume work activities, there was a deterioration in her motivation and drive to excel. She had an intensification of symptoms when she traveled. She could not sleep in hotels or travel in the evening. She became irritable with customers and developed new prejudices. She quit her job after one year and relocated to another state, taking a job with no travel. There was a marked change in the quality of her relationship with her boyfriend. There was a disruption in feelings of intimacy and a lack of sexual interest. In general, there was a feeling



of estrangement from others, a diminished interest and decline in enjoyment of previously experienced activities, and an increasing distrust of people. Her recovery was predicted to be prolonged. Her major psychological defense in coping with the victimization was dissociation ("I would take myself away in my mind when they raped me").

## INCEST AS A SILENT REACTION TO RAPE TRAUMA

Incest—taking advantage of a trusted family relationship—is a type of sexual victimization in which one person exerts pressure over another person of unequal status. In such cases, the person in the position of power uses sex to exploit someone with less power. These victimizations are often prolonged in duration and not reported; thus the term "silent reaction to rape" (Burgess & Holmstrom, 1974).

### *Rape-Incest of 14 Years' Duration: Silent Reaction*

A 20-year-old single woman was admitted to a psychiatric hospital with the chief complaint "I'm depressed and desperate. I've had thoughts of killing myself. There is no reason to live if things don't get better." Other symptoms included decreased appetite, 10-pound weight loss, decreased energy, decreased concentration, a urinary tract infection, and sleep disturbance. She had multiple bruises over her extremities, trunk, face, head, and left eye.

The young woman had had an incestuous relationship with her father since early childhood. She could not remember the details of the early abuse but did remember events since age 15. Her father had been jailed for assault and battery and was released from prison two weeks prior to the patient's hospital admission. The patient lived in an apartment with her father and was fearful he might hurt her if she tried to leave. Since the father's release from prison, he had regularly sexually assaulted her and had physically assaulted her three times. The patient had a history of drinking beer nightly and reported episodic use of cocaine, mescaline, and marijuana. She had felt depressed since her father's return from prison and had active thoughts of overdosing or cutting her wrists. She felt her suicidal thoughts were secondary to her negative feelings about herself because of the long history of abuse by the father. She felt guilty for her father's imprisonment.



*Family history.* The patient's father was an alcoholic who physically beat his wife and children. Her mother had a history of depression and a previous suicide attempt. The patient is the oldest child with two younger brothers and two younger sisters. The youngest sister, aged nine, was described by the father as a "precious and charming child." The 15-year-old sister was described as living on the street. Both brothers had alcohol problems.

The four-week inpatient hospitalization stabilized the young woman. She realized she was able to make choices and decisions about her situation. She was appropriately sad, anxious, and tearful when talking of her situation. A positive pregnancy test depressed her, and she worried her father would find out. She decided to have an abortion. She did not receive many visits from her family and expressed sorrow around this. She began having abdominal cramping and vaginal bleeding, and a therapeutic abortion was completed two weeks after admission. Following this she began expressing stronger feelings of hatred and anger toward her father.

As she began to plan for discharge from the hospital, she talked more of pressing legal charges against her father and asked staff to assist her in going to the police department to follow through with these proceedings. She was visibly agitated and felt frightened of her father's retaliation. She needed staff support while pressing charges.

After the father was charged with rape, the prosecutor decided to secure an expert witness to provide testimony on the dynamics of rape trauma and nonreporting (the defense strategy was to claim the sexual activity was by a consenting adult). The following is part of the victim assessment prepared for the court.

A review of this young woman's 12-14-year history of father-daughter rape-incest supports the dynamics and consequences of such behavior as noted in the clinical literature. Access to the child is through a trusted relationship. In this case, the father negates his parental responsibility of protecting his child and forces the eight-year-old daughter into a sexualized relationship. Isolation of the child was accomplished by the father sending the other children out of the room and to their bedrooms. The mother worked 11 P.M.-7 A.M. and thus [the father] sexually assaulted his daughter in the evenings. He also rendered the mother impotent to intervene. The victim remembers a time when her parents were arguing. She was called in and ordered by the father to tell her mother what the father did. She said: "Father pulls down my



pants and it scares me." Nothing more was said and the father continued the sexual abuse.

The incest activity included oral, genital, and anal sex. The father also wanted [the patient] to talk to him, forcing her to say the activity felt good. He called her degrading names and encouraged her to engage in homosexual behavior with hitchhikers (which she refused).

The incest was maintained through fear and intimidation of all members of the household. The mother was beaten and abused continually. Police would arrest the father; he would get out on bail; charges would be dropped; and this behavior cycled.

The message from the father was that it was OK to have sex with [one's] father; he said it was in the bible, the Noah did it with his daughters. He told [the patient] she should not let society dictate what to do, or what was right, and wrong. He said: "What is wrong about loving your daughter this way?" The father wanted his daughter to have a baby by him. When the daughter tried to stop the incest when she was 16, the father increased his aggression toward her.

There is no way for the daughter to deal externally with the incest. The family knows of the behavior and the police know this man is abusive to his family, but no one is able to stop the father. Psychologically, the daughter dissociates the incest; she blocks it out and is amnesic for specific details. Much of the daughter's early adolescent behavior of running away, early sexualization of peer relationships, and use of alcohol and drugs is motivated by her attempts to get away from the memory and actual incest. The father was brutal and hurt the daughter and the other children continually. The daughter believed, as many incest victims do, that the incest would eventually stop. The reality that control, not sex, is motivating the behavior was realized when the father married a second time and the incest continued.

The support of the psychiatric staff prompted the disclosure of the rape-incest, emphasizing that the father could be stopped if the patient was able to report it to officials. The daughter realized the father's escalation of violence was progressing to a life-and-death struggle. The daughter feared her father would kill her. He has taunted her saying, "Go ahead and tell the cops. It's my word against yours. They will ask why you didn't leave. And remember they can't put me in jail forever."

The impact that a 12-14-year sexual abuse has had on the developing girl and later the young woman can be noted in several ways: (1)



reviewing the details and circumstances of the rape-incest; (2) noting any symptoms that reflect rape-trauma; and (3) citing the dynamics of the victimizer's behavior. The following factors are specific to this case.

1. *The length of entrapment of the victim.* The rape-incest continued over 12 years. The answer to the question of how such behavior can go on so long is in the absolute terror that this man perpetrated on members of his family (Carmen [Hilberman], Rieker, & Mills, 1984). The threats, unpredictable violence, and power held by this man over his family cannot be underestimated. The attachment of the family to this man was through the fear of death if they did not comply. The daughter tried to tell her mother. If a child cannot go to another adult in her environment for protection, it stands to reason that she will not be able to walk out of that environment for help. Also, it is documented that the child protection agency had to intervene in this family and that the children were placed in foster homes at various times.

2. *Psychological defenses employed by the victim to survive the repeated sexual assault.* The victim coped by several means: pleading with the father to stop; telling the father that he was hurting her; cooperating to avoid further trauma; and psychologically dissociating herself during the assaults. When asked how she got through the incest, the victim said she would daydream to a time when "things would be better." The intensity of her anger at her father's behavior was noted in her wish that he was dead. Her rage was so great at her father that she wished never to see him again. She stated, "My insides are numb for what he has done."

Another defense mechanism used was compartmentalization during and after the assault, i.e., trying not to think about what was happening. The power of the compartmentalization led to the naive belief that the incest would stop after her father's second marriage. In reality, the father became drunk on his wedding night, physically assaulted the new wife so that she left and the daughter was again alone with the father.

3. *Symptoms as a result of the post-traumatic stress disorder.* These include mood swings with depression, weight gains and losses, disruption of sleep, nightmares, enuresis in adolescence and adulthood; running away; early use of and experimenting with drugs; and sexualization of peer relationships. There were difficulties in school, including



poor grades and suspension (for which she was beaten with a belt by the father).

Another effect of the incest relationship is the victim's low self-esteem, lack of confidence, and increasing feelings of self-destruction.

4. *The father-victimizer's behavior.* Our understanding of the father's psychopathology in entrapping his daughter in the incest comes from the daughter and the records. The father is described as violent, domineering, demanding, and manipulating. He has terrorized and intimidated the family for years. His manipulation and use of the children are noted in the incest and in an incident, resulting in incarceration, where he sent his oldest son out to steal a car. This man has a very powerful influence over the family, and one senses that his violence is transmitted through the family. The pattern of violence and abuse is ingrained; it is not controllable; it is unpredictable.

The father tries every strategy to control this current charge of rape by his daughter. He writes his daughter letters from prison, telling her he hopes she feels like a "big shot" and that she is happy. He chides her to make a banner that says: "I put my father in jail." He then tries another tactic and claims not to know why she is doing this and asks why is she lying. The father is very clever in his reality distortion and projection. He asks: "How can you ruin my life like this?" However, the daughter's response is: "How could you have ruined my life as you did?"

From a psychodynamic standpoint, the power and control balance in the family has dramatically shifted and the father is escalating in his violence as he begins to lose his potency. His wife dies; he is unable to manage a second marriage; his daughter gathers the strength and support to stop the incest and report him to authorities. As his power and control fail, one would expect the desperate escalation that has been documented.

From a clinical standpoint, the victim is experiencing a chronic post-traumatic stress disorder in which the stressor is the rape-incest of 12 years' duration. She has ever-present intrusive thoughts and recollections of the events; there is a feeling of estrangement from others; she has mood swings and there is a pervasive guardedness in relationships.

When asked how the incest affects her life, the victim says, "I don't trust anyone; I don't understand people; I don't listen to people. I am stubborn. I am upset when I see myself doing what he does. I say things I don't mean. Things around me are moving too fast."



She is frightened of dealing with her internal feelings of fear and rage and of identifying with her father and his aggression. So she becomes suicidal—she internalizes the aggression. She is aware of this identification. She has had fantasies of killing him (with poison). But she would rather die than be like him. Her self-assertiveness is blocked because she does not want to be identified with him. In therapy, one would have to sift and sort through the identification factors with her parents (Carmen [Hilberman] et al, 1984).

She has blocking, difficulty with sequencing and temporal order, and in the recollection of details. Part of this is based on adaptation to very violent traumatic events. The manifestation of symptoms is both a protection and a defense. It has impaired her intellectual abilities, her mental energy, and her level of concentration. A school psychologist's testing of her at age nine (grade 4 grade, which is when the incest began) reveals her having a much higher ability than her schoolwork indicated. She never had the energy to function at her full capacity. Her energies were drained in trying to balance the family conflict.

At trial, the father pleaded guilty to the charge of rape. A copy of the evaluation report on his daughter was made part of his record to accompany him to prison. After the judge read part of the victim report prior to the sentencing, the father admitted his violence in his family and acknowledged that he was unable to control his behavior.

## TREATMENT OF RAPE TRAUMA

Various models of treatment have been used with rape victims. A model that is highly successful in the acute phase is crisis intervention. It was first used by paraprofessionals at rape crisis centers in the early 1970s, and a strong advocacy framework was utilized (Largen, 1985). Most crisis counseling efforts have followed, in modified form, this type of outreach, emergency care, and advocacy assistance programming. The objective of the model is to validate the crisis nature of the event, carefully review the details of the rape, and focus on issues raised by the crisis. This focus is on the assault and its aftermath, with emphasis on assisting the person to achieve mastery over the life-threatening anxiety created by the rape, by identifying a supportive social network and seeking self-enhancing ways of solving problems related to the rape and subsequent events.

Other models used to assist in rape recovery include traditional psychotherapy and cognitive-behavior interventions. The latter include



rational-emotive therapy, cognitive therapy, hypnotherapy, coping-skills therapies, problem-solving therapies, self-instructional training, and interpersonal skills training, to name a few. Among these approaches are various theoretical differences. These theories range from conditioning to cognitive information processing and social learning concepts. Interventions and prescriptions are primarily directed toward interruption of the cognition-affect-behavior-consequences complex. Even though these theories and techniques are implemented in a variety of ways, there are basic assumptions about style and behavior change.

With regard to style, interventions are usually active, time-limited, and fairly structured. We believe that behavior and feeling are largely determined by the way an individual perceives and constructs meaning of the world and self. The techniques are so designed to enhance the person's awareness and control over the cognitions and the behavior responses.

Behavioral change is believed to be an outcome of interrelationships of the person's cognitive structures (schemata, beliefs, programs), internal cognitive processes (automatic thoughts, internal dialogue, images, kinesthetic experiences), internal states (moods, feelings, and their labeling), and external behaviors, which have interpersonal and intrapersonal consequences, feeding back to all the internal processes.

Treatment models need to address the phases through which the victim moves in recovery. The assumption is that there is a general stress-response pattern to the rape that occurs regardless of the past makeup of a person. The stress response requires cognitive reintegration. The coping abilities of the individual, as well as the type of rape and circumstances and the coping methods employed to survive, bear heavily on the victim's recovery. The treatment model provides for interventions that are compatible with the person and her social support system at each phase.

Some victims have either a past or current history of physical, psychiatric, or social difficulties along with the rape trauma. It is clear that these women need careful assessment of both the rape and the prior difficulties for a comprehensive treatment plan. The following is a case example.

### *Chronic Response to Rape Trauma*

Mrs. Jones, a 35-year-old black divorcée, was interviewed a year after being severely assaulted by a Hispanic maintenance man while asleep in her apartment. Mrs. Jones described being awakened early on a



Sunday morning to find a man straddled across her back and battering her head with a heavy pair of pliers. He threatened to kill her if she moved. Mrs. Jones managed to get out from underneath him and noted blood splashing everywhere. The man kept asking for a hammer. During the assault, the assailant raped her by forcing his fingers into her vagina; he also attempted to force his entire hand into her vagina.

Mrs. Jones realized the assailant was going to kill her through the force of the instruments being used against her head, face, and hands. She fought against him successfully and he fled the apartment. Mrs. Jones then sought help within the apartment complex and the police were called. She was taken to a hospital for medical attention.

### *Crisis Response by Time Phases*

Following any traumatic event, two major phases are noted: the period of disruption, which can last as little as a few days to as long as several weeks, and the ensuing period of reorganization. Mrs. Jones had many symptoms and physical problems from the extreme forceful injury to her head and hands. She had numerous stitches to her head and face; her ear needed repair; a thumbnail was detached—to name a few of the medical injuries. She had swelling, pain, numbness, and general soreness of her upper extremities and head area. During emergency surgery, her head was shaved, which served to remind her constantly of the assault. She was afraid to sleep for fear it would happen again. She never returned to the apartment. She startled easily, jumping at any sudden noise. She had mood swings and cried frequently when alone. She was terrified of men, had difficulty concentrating, and was unable to work at previous capacity.

The reorganization phase is the period of time needed for the victim to reconstitute and recover to the degree necessary to resume usual daily activities. Fears and upset from recurring thoughts, feelings, or images were continuing stresses. This phase of recovery had not been achieved by Mrs. Jones within a one-year time period. Nightmares persisted and were characterized by a man with no face attacking her. She continued to experience nightmares several times per week. She had flashbacks, particularly with the sound of metal or what she associated with the sound of pliers. For example, she was in a store when a piece of metal fell and she screamed and flashed back to the experience with the rapist. Another recurring sound is that of the pliers hitting her head. She can be relaxing, lying down, outside, or in a store surrounded by people, and the sound returns. The noise in her head and ears is so great it required neurological consultation.



She has become increasingly agoraphobic, frightened to go outside and to be with friends. Her sleep is limited. She barricades herself in the bathroom, with her feet against the door so that she cannot be taken by surprise and in her sleep if attacked again.

Prior to her assault, Mrs. Jones worked at two jobs, was dating, and had a boyfriend. Her work productivity so declined in the year following the rape that she was warned of possible severance from her work. When her boyfriend heard about the rape, he left, saying that a former girlfriend was raped and he couldn't go through it again. Mrs. Jones continues to be fearful of men and has lost her confidence in being with them.

She is angry and confused at times. She is suspicious and depressed. She believes that she left part of herself in the apartment where the attack occurred. She does not feel she deserved what happened to her, that she was in a place she felt to be safe. She has developed keloids from the injuries, and the daily combing of her hair is a constant reminder of the rape when the comb hits the large scars on her head.

In recalling the assault she is unaware of any pain. Her major source of support is her mother, who lives far away from her. She calls her mother frequently. Her manner is stoic and depressed.

Mrs. Jones relates that the people at work were very helpful and kind to her, as were the police. The interviewer was puzzled by the stoic demeanor and asked if she had prior victimizations. She responded in the affirmative, stating that her husband had raped and beaten her during the marriage. That was her reason for leaving her family and starting her life anew.

### *Discussion*

In evaluating the impact of the rape from the data collected in one interview a year later, two major factors stand out. One is the blitz style of attack and its high degree of brutality. The victim awakened to a life-threatening sound of her skull being crushed and realized she had to defend herself. The auditory recall of that hollow sound is her most distressing flashback symptom.

Although Mrs. Jones' social support system responded with caring and kindness and moved her from the apartment, we wonder whether this has been helpful in the long run. Mrs. Jones states that a part of her life is still in the apartment.

The second impact of this rape is the discouragement over her efforts to change her life. Mrs. Jones complied with the recommendation that she receive psychiatric treatment. However, after the required number



of sessions, her therapist terminated the therapy, stating she was recovering from her depression surrounding the assault. Mrs. Jones' stoic nature successfully kept the therapist from diagnosing post-traumatic stress response and from eliciting a prior history of victimization. Her dominant mood was depression, again further corroborating her complaints of loss. The intensity of this loss became more understandable when it was learned over a year later that she had been assaulted by her husband and the move and new apartment were signs of a positive change in her life.

A compounding intervening variable—the particular life issue at the time of the assault—interacts with the integration of the violence. It may well be that not only the brutality of the rape, but its interaction with prior or ongoing life issues, compounds the response and moves it to a chronic pattern.

Mrs. Jones believes herself deeply aggrieved: it shouldn't have happened. This is a powerful proposition, which may play a role in maintaining symptoms.

Mrs. Jones dealt with a prior traumatic event by moving. This is not unusual and often works until the person again faces adversity and the avoidance defense is rendered inoperable. The nature of the assault thus mitigates against a primary mode of coping. Mrs. Jones is left flooded with anxiety-provoking recollections of the event. She attempts to cope with further avoidance maneuvers and defenses, suspiciousness, avoidance, isolation, to no avail. The nature of the assault, its parallel with prior assault and betrayal, limited coping behaviors, and a social network that also reacts with avoidance behaviors may all be important variables in a chronic response.

## SUMMARY

This review of the relationship of rape trauma syndrome and post-traumatic stress response to acute rape experiences, silent reactions to rape-incest, and chronic response to rape trauma identifies key variables in the four phases related to recovery. It is important for mental health clinicians to understand the historically strong professional bias against rape victims, holding them responsible for the acts committed against them. With new understandings of the traumatic nature of rape, it is hoped that clinicians will be attentive to the trauma and injury suffered by victims and that treatment efforts will be aimed at reducing manifest symptomatology through careful diagnostic and therapeutic skills.



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## *Father-Daughter Incest*

JUDITH LEWIS HERMAN

The incest taboo is universal in human culture. It is generally considered by anthropologists to be the foundation of all kinship structures and the basis of human social order. Though no single definition of the taboo applies among all peoples, virtually every known culture restricts sexual contact within the nuclear family, that is, between parents and children, brothers and sisters. All cultures, including our own, regard violations of the taboo with horror and dread. Breaches of the taboo are viewed not merely as crimes, but as desecrations of the primordial law establishing the place of human beings in the natural and supernatural world. The mythology of many cultures associates violations of the incest taboo with bestiality, cannibalism, and witchcraft (Levi-Strauss, 1949).

Because the incest taboo has been surrounded by secrecy and awe, it is generally assumed that violations of the taboo are extremely rare. In our own culture, this assumption has been tenaciously held until very recently. However, an increasing body of research data, accumulated over the past 30 years, indicates that certain forms of sexual relations between family members are a common occurrence.

### PREVALENCE

In the early 1950s, Kinsey and his associates conducted extensive interviews with over 4,000 women regarding their sexual experiences. Included in the questionnaire was a section on childhood sexual contacts with adults. The results, largely ignored at the time, indicated that female children are regularly subjected to sexual approaches by adult



males who are part of their intimate social world. Twenty-five percent of the women in the Kinsey study reported a sexual encounter with an adult male before age 12. Six percent reported a sexual experience with an adult male relative, and 1% reported an incestuous relationship with a father or stepfather (Kinsey et al., 1953). These findings have since been replicated by other investigators in two large-scale questionnaire surveys of college students (Landis, 1956; Finkelhor, 1978).

There is reason to believe that these prevalence estimates may actually be low when applied to the entire population, since they are based almost entirely on the reports of white, urban, college-educated women. A more recent in-depth interview survey of a random sample of 930 women in California indicates that 38% have had a childhood sexual contact with an adult, 16% with a relative, and 4.6% have been involved in father-daughter incest (Russell, 1984).

Less information is available on the early sexual experiences of boys. Kinsey and his colleagues did not gather systematic data on sexual contacts between boys and adults, believing that such contacts occurred infrequently, but they did indicate that most such contacts were homosexual (Kinsey et al., 1948). Landis (1956) and Finkelhor (1978) surveyed male as well as female college students and reported somewhat discrepant results. In Finkelhor's study, 8.6% of the men reported a childhood sexual encounter with an adult; in Landis' survey, the corresponding figure was 30%. However, both surveys indicated that in cases where boys were abused by adults, the majority of perpetrators (85%) were male. Family members were rarely implicated, and no cases of father-son or mother-son incest were identified.

Thus, the data available from general surveys indicate that incest follows the general pattern of sex offenses, in which the majority of victims are female, and the overwhelming majority of perpetrators are male. This pattern emerges even more clearly from studies of reported cases of incest. In several large-scale studies conducted over the past 30 years, the majority (94%) of cases of parent-child incest that came to the attention of mental health centers, child protective services, or police involved fathers and daughters (Justice & Justice, 1979; Lukanowicz, 1972; Maisch, 1972; Weinberg, 1955).

Only a minute percentage of sexual encounters between children and adults are ever reported to any agency at the time of occurrence, and the more intimate the relationship between perpetrator and victim, the less likely it is that the sexual contact will be disclosed. Thus, for example, in Russell's survey (1984), only 2% of the women who gave



a history of sexual abuse by a family member indicated that the incidents had been reported to the police. Reported incest cases, therefore, represent a very small and probably skewed sample of the total. It is conceivable that cases involving male children or female adults are underrepresented in both case reports and general survey data. Nevertheless, the considerable evidence available to date indicates that the incest taboo is quite commonly breached by fathers and very rarely by mothers, and that daughters are victims far more often than sons.

There are no data associating a particularly high or low prevalence of incest with any social class, racial, or ethnic group. Poor and disorganized families are heavily overrepresented among cases reported to public agencies, probably because they lack the resources to preserve secrecy.

## THE FAMILY CONSTELLATION

Description of incestuous families derive from two sources: clinical reports of families in which incest was detected, and retrospective accounts given by daughters in later life, usually of families in which secrecy was preserved. Clinical descriptions of incestuous families are usually based on direct observation of child victims and their mothers; direct studies of incestuous fathers are understandably rare. Both victim and clinician sources repeatedly identify certain common features, on the basis of which it is possible to construct the outlines of a "family portrait."

The theme most commonly repeated, and which most contradicts popular belief, is the apparent normality and conventional appearance of incestuous families. In most cases, the family structure represents a pathological exaggeration of generally accepted patriarchal norms. Because paternal dominance is socially accepted, the pathological abuse of paternal authority often goes unrecognized. Incestuous fathers are often well respected in their communities. For example, in a study of six military men convicted of incest, the fathers are described as "strongly motivated to maintain a façade of role competence as the family patriarch in the eyes of society" (Lustig et al., 1966, p. 35). The fathers are frequently described as "good providers," and their wives are often completely dependent on them for economic survival. Incestuous fathers often attempt to isolate their families, restricting both the mobility and the social contacts of their wives and daughters. It is not unusual for



the daughters to report that their mothers cannot drive a car, that the family never has visitors, or that they are not allowed to participate in normal peer activities because of their fathers' jealousy and suspiciousness. Finally, incestuous fathers often enforce their dominance in the family through violence. In a survey of 40 women with an incest history, over half reported having witnessed their fathers beating their mothers or other children (Herman, 1981). The daughter singled out for the sexual relationship is usually spared the beatings; however, she understands clearly what might happen to her if she incurs her father's displeasure.

For these reasons, incestuous fathers are often described as "family tyrants" (Cormier et al., 1962; Maisch, 1972; Summit & Kryso, 1978). However, once the incest has been detected, they are unlikely to present themselves in this manner in a clinical interview. On the contrary, they commonly appear pathetic, meek, bewildered, and ingratiating (Walters, 1975). Because they are exquisitely sensitive to the realities of power, they rarely attempt to intimidate anyone who has equal, or greater social status, such as an adult professional. Rather, they will attempt to gain the professional's sympathy and seek to deny, minimize, or rationalize their abusive behavior. Inexperienced professionals may incorrectly conclude that the father is a relatively powerless figure in the family and may even describe the family system as mother-dominated.

Most mothers in incestuous families, however, are not in any position to dominate their husbands; often they can barely take care of themselves and their children. One of the most consistent findings in the literature is the unusually high rate of serious illness or disability in mothers of sexually abused daughters (Browning & Boatman, 1977; Finkelhor, 1978; Herman & Hirschman, 1981; Maisch, 1972). Undiagnosed major mental illness, e.g., schizophrenia, depression, or alcoholism, is frequently observed in the mothers.

One of the most common causes of maternal "disability" in the incestuous family is the mother's inability to take control of her reproductive life. Numerous surveys have documented the fact that incestuous families have more children than the prevailing norms (Herman & Hirschman, 1981; Kaufman et al., 1954; Lukianowicz, 1972; Maisch, 1972; Tormes, 1968).

Economically dependent, socially isolated, battered, ill, or encumbered with the care of many small children, mothers in incestuous families are generally not in a position to consider independent survival and must therefore preserve their marriage at all costs, even if the cost includes the conscious or unconscious sacrifice of a daughter.



Incestuous fathers do not assume maternal caretaking functions when their wives are disabled; rather, they expect to continue to receive female nurturance. The oldest daughter is usually deputized to take on a "little mother" role, often assuming major responsibility for housework and child care (Herman & Hirschman, 1981; Justice & Justice, 1979; Kaufman et al., 1954; Lustig et al., 1966). The daughter's sexual relationship with the father often evolves as an extension of her other duties.

Sexual estrangement of the marital couple is frequently cited as a factor in the genesis of incest. However, careful interviewing of offenders and their wives indicates that most incestuous fathers continue to have sex on demand with their wives as well as with their daughters; those fathers who confine their sexual activities to their children do so by choice (Groth, 1979). Furthermore, in many cases, fulfillment of the father's aggressive rather than sexual wishes may be the primary motivation for the incest. Like other sex crimes, incest may be seen as the expression of a wish for power and dominance. Cavallin (1966), who administered psychological tests to convicted incest offenders, concluded that the incest was an expression of hostility to all women, and that the daughter was selected as the victim because she was perceived as the woman least capable of retaliation. Similarly, alcoholism, though frequently observed in the fathers, does not seem to play a determining role in the development of overt incest; problem drinking is reported as frequently in fathers who are seductive but not overtly incestuous, and in the general population (Herman & Hirschman, 1981). To be sure, many fathers attempt to excuse their behavior by attributing it to "demon alcohol"; however, careful interviewing again reveals that the compelling sexual fantasy is present when the father is sober. He may drink in order to provide a "timeout" during which he can disclaim responsibility for his actions (Groth, 1979). The actions, however, are not impulsive but carefully planned.

The description of the incestuous father has been remarkably stable over time. For example, Gordon (1981) studied case reports from child protective agencies in the late nineteenth and early twentieth centuries, including 73 documented incest cases. Incestuous fathers were often described as violent, but in contrast to those fathers reported for physical child abuse, they were not under particularly severe social stress, did not see the sexual abuse as a loss of control, and usually expressed little contrition or nurturant concern for their daughters. Gordon remarks further: "Often the incest assailant did not even experience the coercive aspects of his behavior as wrong because he was accustomed to the



use of force in having his way sexually. Incest was often coincident with coercive, brutal, or other non-mutual sexual relations with wives or adult lovers."

Diagnostically, it has been difficult to characterize incestuous fathers, other than to note that most of those who have been directly observed are not psychotic and are of normal or above-average intelligence (Cavallin, 1966; Gebhard et al., 1965; Groth, 1979; Maisch, 1972; Weiner, 1962). The fathers' attitude of entitlement to female service, and their willingness to use coercion to obtain it from their wives and daughters, indicate a kind of circumscribed sociopathy, limited to the family and not ordinarily displayed in other social situations (Summit & Kryso, 1978). Because paternal domination of the family is accepted and condoned, we lack a diagnostic category that recognizes this extreme paternal dominance as a form of psychopathology. About the best we can do is locate the fathers somewhere in the ill-defined range of personality disorders. In addition, the incestuous behavior, once established, has repetitive and compulsive aspects which liken it to an addiction.

## THE INCEST HISTORY

Incestuous abuse usually begins when the child is between the ages of 6 and 12, though cases involving younger children, including infants, have been reported (Herman, 1981; Russell, 1984). The sexual contact typically begins with fondling and gradually proceeds to masturbation and oral-genital contact. Vaginal intercourse may not be attempted, at least until the child reaches puberty. Physical violence or threats may not be employed, since the overwhelming authority of the parent is usually sufficient to gain the child's compliance. The sexual contact becomes a compulsive behavior for the father, whose need to preserve sexual access to his daughter becomes the organizing principle of family life. The sexual contact is usually repeated in secrecy for years, ending only when the child finds the resources to escape. The child victim keeps the secret, fearing that if she tells she will not be believed, she will be punished, or she will destroy the family (Herman, 1981; Summit, 1982). The consequences of breaking secrecy are often represented to the child as loss of a parent ("Your mother will have a nervous breakdown"; "I'll be put in jail") or expulsion from the family ("You'll be sent away"). These prospects are terrifying to any child. In addition,



in some cases positive inducements are offered to the child for continuation of the incestuous relationship. The daughter may be singled out for special attention, privileges, or gifts and may in the process be alienated from mother and siblings, who are jealous of the "special" father-daughter relationship but unaware of the overt sexual involvement. Usually the father employs some combination of violence, threats, and positive inducements.

Clinicians frequently assert the belief that the mother is aware of and "complicit" in the sexual relationship (Kempe & Kempe, 1978), and cases have been documented in which this is undeniably true (Tormes, 1968). However, in retrospective reports, the majority of daughters indicate that they never told their mothers (Herman, 1981; Lukanowicz, 1972). Rather, they gave vague and indirect indications of distress and felt betrayed and disappointed when their mothers failed to recognize the nature of the problem.

Distress symptoms frequently displayed by incestuously abused children include insomnia, nightmares, bedwetting, fearfulness, social withdrawal or misbehavior, and somatic complaints, particularly lower abdominal or pelvic pain (Adams-Tucker, 1982; Burgess & Holmstrom, 1978a; De Francis, 1969; Sgroi, 1978). A few children may attempt to reenact the sexual encounters with younger playmates. These symptoms comprise a classic picture of post-traumatic stress disorder.

As the child reaches adolescence, distress symptoms may heighten for several reasons. First, the father may increase his sexual demands, attempting intercourse for the first time. This added intrusion, as well as the risk of pregnancy, makes continuation of the incestuous relationship increasingly intolerable for the child. In addition, the normal course of the girl's maturation, which at this stage of life includes increased awareness of sexual norms and increased social involvement with peers, inevitably represents a threat to the maintenance of the incest secret. The father frequently responds to this threat with jealousy verging on paranoia and may attempt to place severe restrictions on his daughter's social contacts. The result is an increase in family conflict and escalating symptoms of distress. Runaway attempts, suicide attempts, drug and alcohol use, hysterical seizures, indiscriminate sexual activity, and early pregnancy are frequently seen in teenage incest victims (Benward & Densen-Gerber, 1976; Goodwin, 1982; Herman, 1981).

As the oldest daughter becomes more resistant and threatens to escape entirely from the incestuous relationship, the father may turn his attention sequentially to younger daughters. Repetition of the incest with



more than one daughter or with other available children (nieces, step-children, grandchildren) has been a common finding of numerous clinical reports (Cavallin, 1966; Herman, 1981; Lukianowicz, 1972). On the other hand, there are virtually no clinical reports of cases in which an incestuous relationship was spontaneously ended by the father's initiative and choice. It seems reasonable to conclude that once an incestuous relationship has begun, the father will seek to perpetuate it, either with the first victim or with another, as long as he can.

The present state of knowledge of the incestuous family constellation and the course of the usual incest history permits a tentative identification of high-risk situations. Father-daughter incest should be suspected in any family that includes a violent or domineering and suspicious father; a battered, chronically ill, or disabled mother; or a daughter who appears to have assumed major adult household responsibilities. Though the oldest daughter is particularly vulnerable, once incest has been reported with one child, all other children to whom the father has intimate access should be considered at risk. Incest should also be suspected as a precipitant in the behavior of adolescent girls who present to an agency as runaways, "sex delinquents," or with drug abuse or suicide attempts (Herman & Hirschman, 1981).

## IDENTIFICATION OF INCESTUOUS FAMILIES

Effective intervention in incestuous families begins with identification of the problem. Given the prevalence of incest and other forms of child sexual abuse and the evidence of psychiatric morbidity, a strong case can be made for including questions about sexual contacts between adults and children routinely in all clinical evaluations. The main obstacle to obtaining a history of incest is the clinician's reluctance to ask about it. Incest provokes strong emotional reactions, even among seasoned professionals. Denial, avoidance, and distancing are universal responses. Clinicians may have particular difficulty considering the possibility of incest in families of racial, ethnic, religious, or class backgrounds similar to their own, whereas families that are comfortably different may be more easily suspected.

For a clinician who has mastered these countertransference reactions, obtaining a history does not present unusual difficulties. Calm, direct questioning is often sufficient. For children, some specialized interviewing techniques have been developed; including the use of drawings and



anatomically correct dolls (Adams-Tucker, 1982; Burgess & Holmstrom, 1978b). Using these materials, even very young children are able to describe what has happened to them and to distinguish fantasy from reality. False complaints of sexual abuse are rare (less than 5%); on the other hand, it is common for a child to retract a true allegation under pressure from the family (Family Crisis Program, 1984; Goodwin, 1982).

## CRISIS INTERVENTION

The discovery of incest represents a major family crisis, requiring rapid and decisive intervention. Usually, by the time of disclosure, the incest has been going on for several years, and the family's defenses have been organized around preservation of the incest secret. Disclosure represents a serious disruption to established patterns of functioning and a threat to the survival of the family. The father faces loss of the sexual activity which has become an addiction. He also faces possible loss of his wife and family, social stigmatization, and even criminal sanctions, though in practice these are virtually never applied. The mother faces possible loss of her husband, social stigma, and the terrifying prospect of raising her family alone, a task for which she is ill prepared.

In this situation, the father usually reacts by maintaining steadfast denial. He insists that the child is lying and directs his efforts to persuading his wife and outsiders that he is innocent. The mother finds herself torn between her husband and her daughter. Though she may initially believe the child and attempt to take protective action, unless she receives rapid and effective support, she will usually rally to her husband's side within a short time. If she persists in believing her child, she has a great deal to lose and very little to gain. The daughter, therefore, may find herself discredited, shamed, punished for bringing trouble on the family, and still unprotected from continued sexual abuse. Suicide and runaway attempts are particularly likely at this time. Without effective intervention, the child may be scapegoated and driven out of the family.

Unfortunately, most therapists are not well prepared to intervene in this crisis, because they fail to recognize incest either as criminal or as addictive behavior. This can be seen most commonly in the resistance to the use of criminal terms, such as "offender" and "victim," and in



the failure to report incest to child protective agencies, even though such reporting is mandated by law. Naive therapists may tend to accept the offender's denial or his assurances that the sexual abuse has stopped. Therapists may also be seduced by the offender's rationalizations, all of which are widely supported in popular and professional culture. The most common rationalizations are, first, that incest is harmless, or would be if not for prudish social condemnation; second, that incest is consensual, and that children are willing participants; and third, that incest is simply a response to deprivation of adult sexual expression and can be treated as such.

Failing to recognize the criminal and addictive nature of the abusive behavior, the therapist may approach the family as though incest were merely a symptom of family dysfunction. He may attempt to treat the underlying dynamics, using a traditional individual or family therapy model in which the therapy contract is freely chosen, one therapist assumes full treatment responsibility, and the rule of confidentiality is observed. This model, which is useful and appropriate for neurotic and some psychotic patients, is ineffective for addicts and for character-disordered patients who commit crimes (i.e., for incest offenders). Successful crisis intervention with incestuous families requires an active, directive, even coercive approach, and it requires ongoing cooperation between the therapist and agencies of the state: law enforcement and child protective services. No therapist can treat incest alone (Summit, 1981).

Because the problem of incest has only recently claimed the serious attention of mental health professionals, principles and techniques of therapeutic intervention are still in the early stages of development. Successful intervention with the incestuous family clearly requires a high degree of institutional coordination, clinical sophistication, and plain hard work. Well-documented treatment outcome studies do not as yet exist, and even published program descriptions are rare. The following treatment guidelines are derived from site visits to five of the most fully developed treatment programs in different areas of the country, and from verbal reports of clinicians working in 40 to 50 other programs. They represent an attempt to define points of consensus and of controversy among experienced clinicians in the field. A fuller elaboration of these guidelines may be found elsewhere (Herman, 1981).

The initial focus of crisis intervention should be on stopping the sexual abuse and establishing a safe environment in the family. Reporting to the mandated authorities should be done promptly, preferably



in the presence of the family, and should be explained as a protective, nonpunitive measure. The therapist must assume that the child's complaint of sexual abuse is valid and should not be confused by initial denial by the parents.

Once the incest has been reported, debate often revolves around whether or not the child should be temporarily removed from the home. In some cases this appears to be the only practical means of ensuring the child's safety. However, this intervention is destructive to the child for several reasons. First, it makes her feel that she had done something wrong and is being punished by banishment from her family; second, it reinforces the tendency of the parental couple to bond against the child; and third, it is difficult to find an appropriate placement for the child. If safety cannot be guaranteed at home, it is preferable to have the father leave during the crisis period. Unfortunately, child protective agencies do not have the legal authority to remove a parent from the home; however, this result can often be accomplished either by persuasion or in some states through the use of civil protection laws. A court order may be obtained requiring the father to vacate the home and to provide child support for a limited time. Conditions for supervised visitation and for mandated treatment may also be established by the court. Clinicians working with incestuous families should become familiar with these legal procedures.

During the crisis period, all family members are in need of intensive support. The child needs to be assured that there are protective adults outside her family who believe her story and will not allow her to be further exploited. She should be praised for her courage in revealing the incest secret, assured that she is not to blame for the incest, and told that she is helping, not hurting, her family by seeking outside help. She should also be told explicitly that many children retract their initial complaints, and that she will not be abandoned should this happen in her case. The mother needs help believing her daughter and resisting the tendency to bond with her husband against the child. If the couple separates, the mother also needs help with issues of practical survival. Previously untreated health problems should also receive prompt attention. The father needs help facing the fact that secrecy has been irrevocably broken, and that he must now admit and give up the sexual relationship with his daughter before the family can be restored.

The crisis initiated by revelation of the incest secret is resolved at the point that the family is under the supervision of the mandated agency and a coordinated treatment plan is in place. Cooperation



between all professionals working with the family facilitates quick and effective crisis intervention and greatly improves the prospects for treatment.

### TREATMENT IN THE POST-CRISIS PERIOD

Following the crisis of disclosure, the incestuous family is generally so divided and fragmented that family treatment is not the modality of choice. Experienced practitioners who have begun programs with a family therapy orientation have almost uniformly abandoned this method except in late stages of treatment (Giarretto et al., 1978). Group treatment for mothers, fathers, and child victims appears to be a far more promising approach. In some cases, individual, couple, or family therapy may also be recommended. For all family members, the issues of stigma, isolation, and poor self-esteem are especially amenable to group treatment. For fathers, group treatment is effective also in breaking through denial and rationalization of the criminal behavior. Many group programs for offenders follow a highly structured model similar to programs for treatment of alcoholism and other addictions. In early stages of treatment, the offender acknowledges that he has lost control of his behavior and must submit to external control. Progression through the program involves increasing acceptance of responsibility for present behavior and restitution to others for past abuses (Brecher, 1978; Silver, 1976).

Opinion is divided on whether incest offenders can be motivated to remain in treatment without a credible threat of criminal sanctions for failure to comply. To date, the most highly developed treatment programs for incest have been those which rely on a court mandate (Berliner, 1981; Giarretto et al., 1978). No program has yet demonstrated an ability to engage offenders in sustained treatment without legal sanctions.

In addition to group and individual treatment, many programs incorporate a partial self-help component, most frequently called Parents United and Daughters and Sons United. Self-help activities supplement more formal therapeutic work in a number of ways. During the crisis period, the family's intense need for support may be met by frequent peer contact. The father in particular may be more easily persuaded to admit the incest and cooperate with a treatment program if he is rapidly put in contact with other offenders who have successfully participated in treatment. In the postcrisis period, families beginning treatment may



benefit from the experience of those further along, and "advanced" group members may gain self-esteem from being in a helping role. Finally, after formal treatment is terminated, self-help groups provide a continued source of support and community.

## CRITERIA FOR TERMINATING TREATMENT

Restoration of the incestuous family centers on the mother-daughter relationship. On this point, there seems to be wide consensus among experienced practitioners, even those most committed to reuniting the parental couple (Giarretto et al., 1978). Safety for the child is not established simply by improving the sexual or marital relationship of the parents; it is established only when the mother feels strong enough to protect herself and her children, and when the daughter feels sure that she can turn to her mother for protection.

The father may be judged ready to return to his family when he has admitted and taken full responsibility for the incest, apologized to his daughters in the presence of all family members, and promised never to abuse his children again. When the father is ready to return to the family, the family may or may not be ready and willing to receive him. This choice properly rests with the mother, once the mother-daughter bond has been restored, and once neither mother nor daughter feels intimidated. A decision for divorce may be as valid as a decision to rebuild the marriage; certainly the preservation of the parents' marriage should not be considered the criterion of therapeutic success. Probably the best gauge of successful treatment is the child victim's subjective feeling of safety and well-being, the disappearance of her distress symptoms, and the resumption of her interrupted normal development.

Given the present state of therapeutic knowledge, no one can claim to "cure" incest; rather, the behavior may be brought under control, first by outside intervention, second by empowering the mother as a protective agent within the family system, and finally to a limited degree by developing the father's inner controls. The father's internal controls should never be considered sufficient to ensure safety for the child; if the family decides to reunite, mother and daughter should be explicitly prepared for an attempt to resume the incestuous relationship (Groth, 1979). Some degree of outside supervision should probably be maintained as long as children remain in the home.



Further investigation is needed in order to continue the development of effective treatment for all family members. Direct clinical studies of incestuous fathers are still quite rare and largely confined to convicted offenders, who comprise a very small and skewed sample. Long-term follow-up studies of treated and untreated families and comparative studies of differing treatment approaches are needed in order to document what is at present part of the oral culture of recent clinical experience.

### LONG-TERM SEQUELAE OF INCESTUOUS ABUSE IN CHILDHOOD

No long-term prospective study of sexually victimized children has ever been carried out. Even if the formidable technical barriers to the organization of such a study could be overcome, it would not be ethically possible to study such children without disclosing the abuse or intervening to prevent its continuation. Since the majority (98%) of cases of intrafamilial child sexual abuse are not disclosed, the only currently practical method of discovering the long-term consequences of such abuse is retrospective study of adults with a history of victimization.

The largest such study is Russell's probability survey of 930 women in the San Francisco area (1986). This is a nonclinical sample of women currently living and functioning in the community. Women institutionalized in mental hospitals, shelters, brothels, drug treatment programs, and the like were not included, nor, for obvious reasons, were women in the comparable age cohort who had already died from accidents, suicide, murder, or other causes. Thus, women with severe disturbances that might have been related to early trauma were not detected by the survey, and the estimates of long-term harm should therefore be considered minimal.

Evaluation of long-term consequences of incestuous abuse was carried out both by self-report measures and by comparison of abused and nonabused groups. The respondents' own estimates of the degree to which their childhood abuse histories had affected their lives tended to correlate well with objective measures. One-quarter of the respondents estimated that the incestuous abuse had had a great effect on their lives; approximately equal percentages estimated that the abuse had had some or little effect; and 22% reported no long-term effects. The



effects more frequently cited by respondents were distrust and fear of men, lowered self-esteem, and fear of sex.

When compared with women who had not been incestuously abused, the incest victims did not fare well in their sexual and intimate relationships. Abused women were significantly more likely to experience early pregnancy, marital separation and divorce, and repeated sexual victimization, including marital rape. Sixty-eight percent of the incest victims reported a rape or rape attempts, as compared to 38% of the women who had not been incestuously abused in childhood. Perhaps in response to their repeated experiences of the world as an unsafe place and other human beings as untrustworthy, incest victims were also much more likely than others to lose their faith in God. Many more victims than nonvictims defected from the religion in which they had been brought up.

Within the victimized group, the severity of long-term trauma appeared to be related to the degree of violence and physical violation, the duration of the trauma, the age difference between the victim and perpetrator, and the relationship between victim and perpetrator. Abuse by fathers and stepfathers was judged to be the most harmful: 82% of the women abused by fathers or stepfathers reported extreme or considerable trauma. Abuse by brothers resulted in extreme or considerable trauma in 60% of cases, and abuse by other relatives outside the nuclear family, in 40%-50% of cases.

Clinical studies of adult patients with a history of incestuous abuse report consistent findings of symptoms consistent with chronic or delayed post-traumatic stress disorders, as well as persistent impairments in self-esteem, self-protection, identity formation, and intimate relationships. Patients are chronically anxious or fearful and often have chronic sleep disturbances or insomnia. A need for vigilance at night may have become integrated into the patient's character structure and adaptively expressed in a choice of occupation (for example, security guard or night-shift nurse). Reenactments of the trauma occur in flashbacks, often triggered by attempts at sexual intimacy, nightmares, self-mutilation, and repeated victimization. Ego constriction is most noticeable in persistent deficits in self-care and self-protection, and sometimes also in social withdrawal or isolation. Many patients also complain of emotional numbing and chronic dysphoria and describe themselves as "in a fog" or "behind a glass wall." Memory deficits for childhood experiences may become apparent. Patients will often describe a conscious induction of dissociative states or repression, originating in their childhood attempts to cope with overwhelming sexual trauma (Herman,



1981; Gelinas, 1983; Meiselman, 1978). Heightened aggression directed against the self frequently results in suicide attempts and self-mutilation (Herman, 1981).

Given the incest victim's apparent difficulty with self-esteem and self-protection, she may be at unusually high risk for marriage to an abusive spouse. For this reason, the potential for repetition of the incest in the next generation must be considered. The phenomenon of "generational transmission" has frequently been reported anecdotally (Meiselman, 1978; Raphling et al., 1967; Straus, 1981; Tormes, 1968; Weiner, 1962). Goodwin (1982), in the only controlled study to address this issue, documented a significantly higher prevalence of incest history in mothers of abused children compared to a roughly matched group of "normal" mothers. Among the mothers from families involved in child abuse, 24% reported an incest history, compared to 3% of the control group. It should be noted, however, that in this study, three-quarters of the mothers of abused children did *not* have a history of sexual abuse in their own childhood, a finding that should lean to caution in the facile application of the generational-transmission hypothesis. A second potential mechanism of generational transmission may be traced through the sons of incestuous fathers, who may develop abusive behavior in identification with their fathers. Anecdotal reports of such behavior are increasingly prevalent, but no controlled studies have as yet been done to document this phenomenon.

#### TREATMENT OF ADULTS WITH A HISTORY OF INCEST

Adult women with a history of incest are frequently found among psychiatric patients. For example, Carmen and her associates (1984), in a retrospective survey of 188 psychiatric inpatients, found that 28% of the female patients had a history of sexual abuse, most of which was intrafamilial. Histories of sexual abuse are also common in women who present to community treatment agencies as prostitutes (James & Meyerding, 1977) or battered women (Center for Women Policy Studies, 1979). A history of sexual abuse has been etiologically linked to some specific psychiatric syndromes, such as multiple personality disorder (Putnam & Post, 1982), and is suspected in a significant proportion of women receiving the diagnosis of borderline personality disorder (Briere, 1984; Herman, 1986). Incest victims can present as difficult patients.



For example, Meiselman (1978) describes incest victims in outpatient treatment as more symptomatic and more disturbed than a comparable group of patients who had no victimization history.

As in the case of child victims, successful treatment of the adult with a history of victimization begins with obtaining a history. The willingness of the victim to disclose her abuse history is entirely dependent on the clinician's willingness to hear, respect, and validate the patient's experiences and to bear, with the patient, all the associated affect. With increasing tolerance, the clinician can expect to hear an increasing number of histories that include atrocities. The limits of the clinician's own affect tolerance are constantly challenged. For this reason, the clinician who works with victims must be assured of dependable access to supportive peers in order to cope with the contagion of post-traumatic stress disorder that affects caregivers.

Male and female therapists often differ in their countertransference responses to victims. These differences may result in staff splitting along gender lines in institutional settings and may lead to different but equally common therapeutic mistakes. Female therapists often tend to overidentify with the victim, becoming overwhelmed by feelings of helplessness and despair or with rage against the offender that the victim may not share. They may tend to shy away from exploring the actual details of the sexual encounters. Male therapists, on the other hand, may tend to identify with the offender. They may focus on aspects of the victim's behavior that might have been interpreted as provocative and may have difficulty supporting the victim's anger against the offender. Male therapists may also find incest victims sexually arousing. This may lead to inappropriate behaviors ranging from premature, intrusive questioning about the details of the sexual encounter to actual seduction attempts. Since an estimated 5%-10% of male therapists seduce their patients (Holroyd & Brodsky, 1977; Kardener et al., 1973), and since incest victims appear to be extremely vulnerable to repeated victimization, the risk in such therapeutic encounters must be considered high. It is perhaps unnecessary to state that any such seduction, however rationalized, represents a repeated trauma to the victim.

Establishment of trust in the context of a therapeutic alliance is the central task of treatment. Early and explicit clarification of this issue is essential. The patient should be told that, *regardless of her behavior*, the fact that she had an incest experience means that she was not properly cared for. Her difficulties in establishing trusting relationships and her



own lack of entitlement to self-care should be explained as consequences of abuse. Post-traumatic symptoms and defensive strategies should also be identified. Repeated testing of the therapist's trustworthiness should be anticipated and clarified with the patient.

Once a therapeutic alliance has been established, grieving for both parents and for the lost childhood should be expected. Patients may experience a period of existential despair as they give up their belief that their own intrinsic badness was responsible for their victimization, and their own efforts to be good can preserve the hope for a fantasied good parent. Suicidal, self-destructive, or regressive episodes may occur during this process. However, at the same time, the beginnings of new, more adaptive behavior may also be discerned. As the patient works through her rage and grief, she gives up her negative identity. Self-esteem, self-protection, and peer relationships begin to improve.

Because the trauma of incest is profoundly social, so is the recovery process. A full resolution of the trauma involves restoration of social bonds and renegotiation of the patient's relationship with her family of origin. Group treatment and self-help are particularly useful in the recovery process, either in addition to individual psychotherapy or as a sole treatment modality. Both group treatment and self-help utilize the victim's great capacity to be helpful to other victims. In a peer group, victims are permitted a controlled, protected regression and given an opportunity for catharsis in safety, but also offered an occasion to utilize their strengths. Mature defenses such as anticipation, altruism, and humor are mobilized in aid of the recovery process. For patients with memory deficits, group treatment provides a powerful stimulus for recovery of memories. Disclosures, limit setting, and confrontations with family members are also more likely to be successful if carefully planned in a group setting and carried out with group support. A fuller discussion of group treatment may be found elsewhere (Herman & Schatzow, 1984).

Further research is needed to clarify the process by which victims recover from childhood sexual trauma. The critical importance of supportive relationships, including but not limited to the therapeutic relationship, is repeatedly cited in the testimony of victims. For example, Tsai and her associates (1979), in a study of victims recruited by radio advertisement, compared a group who considered themselves well recovered and a group who complained of persistent long-term sequelae of their childhood trauma. Many of the women who escaped without permanent harm attributed their recovery to helpful intervention from other people. Most frequently cited were supportive friends and family



members, who assured these women that they were not at fault, and patient lovers, who helped them reclaim their sexuality. In another study, victims who were well recovered as evidenced by greater marital satisfaction and capacity to protect their children were those who in childhood had told others about the abuse and received a supportive environmental response (Straus, 1981). Although supportive intervention at the time of the abuse is the most desirable, even long-belated social support, such as that experienced in adult survivor groups, appears to be effective in the recovery process. In the words of one survivor:

The continuing greatest benefit of the group is the defeat of the sense of aloneness, alienation, and separation from the "normal" world that I felt all my life and that intensified once I remembered and acknowledged the fact of incest in my experience. In the group I discovered that I wasn't alone. . . . I learned that people cared about me and what had happened to me, and I faced the fact that this terrible thing had happened to other women who, obviously to me, were innocent victims of violation. Their stories and their compassion helped me to extend the caring—and anger—I felt for them to my own self as a child. I stopped feeling like a monster.

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# 9

## *Post-Traumatic Therapy for Children Who Are Victims of Violence*

CAROL T. MOWBRAY

Perhaps no other subject evokes as much sympathy for the victim or as much revulsion for the victimizer as that of children who are subjected to violent treatment. It may thus seem ironic that the literature on such a critical topic is sparse. Perhaps it is a reflection of the emotionality associated with the subject of child victims that so little rational, scientific study has been carried out. This chapter summarizes what literature is available from case studies and research on child victims. However, the few reports included are extremely diverse and many involve nonrepresentative, highly biased cases, so generalizations from them must be quite tentative. To supplement the literature review, this chapter also presents an overview of issues in child development relevant to the adult victimization literature, suggesting ways in which child victims may differ from adults in their reactions. The final section of this chapter coalesces these inductive conclusions with generalizations from the literature into recommended considerations for assessment and intervention in the prevention and treatment of trauma in child victims.

### CHILDREN'S DEVELOPMENTAL STAGES

#### *Cognitive*

Perhaps the cornerstone for understanding the child's reactions to major life experiences, including victim trauma, is an adequate assess-



ment of how he/she views the world, e.g., the child's stage of cognitive development. Egocentrism is a major feature of young children's cognitions. As defined by Piaget (in Flavell, 1983), egocentrism is the cognitive state of seeing the world from your own point of view only, without awareness that you are looking *only* from your own viewpoint. Thus, egocentrism is the absence of both self-perception and objectivity. Because of their egocentrism, young children tend to establish their cognitions based on appearances and do not understand permanence or the fact of unvarying laws in the universe (such as conservation). Also, because of egocentrism, young children lack empathy for others. They cannot be sympathetic to others' pains, sorrows, or feelings, because they simply do not have any notion of what another person is experiencing. Egocentrism also relates to children's attribution of motives and feeling states to others and to things: they assume that everything is oriented toward themselves. For instance, children believe that the sun is following them; if someone dies, he has gone away from the child; if there is a flood, it's because of something *the child* did. Children's egocentric perspectives can be major factors in their understanding the victim experience and their fears of being revictimized.

Of particular relevance for victim reactions is children's developmental understanding of death. At ages three to five, death is not permanent, but merely living on under changed circumstances. Any sorrow associated with death is because of separation. From ages six to eight, death is seen as an external agent, often monsterlike, who can catch you and take you away. But if you see it coming in time, you can escape. By age nine, however, children have attained a more adultlike concept of death as the end of life. Since victimization is often associated with temporary or permanent loss through death of significant others and usually involves death anxiety, the child's conceptions of death need to be taken into account in determining victim trauma. Although young children may experience less death anxiety because they see death as impermanent or escapable, it should also be remembered that separation is much *more* anxiety-producing for them than for older children and adolescents.

### Moral Development

A substantial body of research and literature exists describing children's stages of moral development. Piaget has identified major differences in the moral orientations of younger versus older children. Younger



children judge the immorality (badness) of actions directly in relationship to the seriousness of the consequences, without taking into account the motives involved. Thus, a child who accidentally and unavoidably breaks 15 cups is "naughtier" than one who breaks one while doing something he was told not to do. Young children also believe in imminent justice—that Nature will punish misdeeds. For example, given the story of a boy caught stealing apples by a policeman, who then runs away across a river and the bridge breaks, young children believe the bridge broke because he was bad (Flavell, 1983).

Kohlberg (1964) has constructed overall stages of moral development. In the early premoral stages, children are oriented strictly toward punishment and obedience or hedonism. At the middle, "conventional rule-conformity" stage, morality is seen in terms of maintaining the approval of others or a reliance on authority. Finally, the most advanced stages are based on a "morality of self-accepted moral principles," such as contractual obligations or individual principles or consequences (Mussen et al., 1974). Combined with young children's egocentrism, their primitive sense of moral development may have some serious consequences for how they react to traumatic events. First, if serious damage or injury has occurred to others but not themselves, children may blame themselves, whether or not they had any culpability—and the more serious the damage, the greater the self-blame. If adult reactions are to blame the victims, children will undoubtedly accept this. Furthermore, because of their beliefs in imminent justice, they will probably expect that Nature will invoke the same damages on them. Young children may also experience more self-blame and guilt and consequently more fears of retribution because their egocentrism leads them to attribute real power to their thoughts and fantasies; so if they wished something bad would happen to their sister, parents, etc., and it did, they would feel responsible. Because of their absolutist morality and orientation to authority figures, young children may also feel that if something bad happens to them (e.g., as a victim), then they *must* have deserved it.

### *Coping and Defense Mechanisms*

Another developmental area relevant to children's reactions to victimization is their coping and defense mechanisms. This area has been less clearly defined into stages, but many age differences still can be noted. At the earliest ages, children's fears are directly and obviously expressed: crying, trembling, clinging. As children grow older, they are



encouraged not to show their fears and anxieties. Consequently, disguises, or defense mechanisms, are developed. The most basic and earliest-appearing defense mechanisms are introjection (incorporating something external into the self), identification (incorporating characteristics of other persons into the self), and denial (altering reality to make things the way the child wants them to be). Repression is more complex than denial, involving making unconscious an unwanted feeling, memory, or thought. Children in the middle years also more often use defense mechanisms of projection and displacement—attributing an unwanted affect to someone else or to some other cause; reaction formation, undoing, and isolation—wherein a feeling is repressed and a defense constructed to keep it repressed, e.g., excessive attitudes, feelings, or actions or separating the repressed from the rest of the self; and repression and fixation—displaying behaviors from younger ages. Adolescent defense mechanisms may include any of the aforementioned, but are expanded to include intellectualization mechanisms—attempts to turn personal affects into the impersonal, abstract, and unemotional.

### *Reactions to Grief and Mourning*

Children's reactions to loss are relevant to victimization for two reasons. First, children who are victims frequently suffer temporary separations from parents or permanent losses of significant others. Second, adult reactions to victimization have often been compared to the stages found in grief and mourning. Mowbray (1980) summarized the literature on children's reactions to object loss and identified developmental stages as follows: For the youngest toddlers, loss is felt mainly in terms of separation. With two-to-four-year-olds, their reactions are likely to be more disturbed, but with a limited means of expression, they may appear to not be reacting at all. Behavioral symptoms should be watched, e.g., aggressive behavior, eating and sleeping disorders, tics and nervous mannerisms, or actively seeking out substitutes. For these children in the autonomous stage, it is important that the child not connect achievement of developmental tasks with disappearance of the loved object. For children aged four to seven, there is more experience of actually missing the person versus fears of having their own needs met. Although children of this age *can* accept the reality of death, all of its ramifications may not be envisioned. Thus, they may, at times, expect the individual to return. They also show other illogical patterns: associating death with badness and, based on their



own egocentrism, blaming others or themselves more. They also show more somatic distress, more worries and fears, coping through play behavior, and some tendency to compensate through pseudoadult behavior.

In latency-age children, there is a more accurate understanding and fewer somatic complaints, worries, and fears. However, there seems to be more expression of self-deprecation and use of fantasy as a restitutive mechanism.

Finally, although adolescents have an adult cognitive understanding of death, their emotional development is immature. They fear death but inhibit direct expression of their feelings—without a firm identity status, they avoid behavior that expresses vague individual concerns. Yet, they are likely to experience more guilt and self-deprecation than children do. Emotional outlets are often seen in intellectualizations and focusing on future plans.

With this developmental perspective as background information for understanding children's victimization responses, we shall now turn to the literature of research and case studies on child victims.

## LITERATURE REVIEW

Case studies and research reports on child victims in the following categories were reviewed: victims of natural and man-made disasters, children affected by the Holocaust and political terrorism, children who were sexually assaulted,\* and children who were crime victims or witnessed other crimes. Overall, this literature shows great diversity in children's responses, enormous situational variations, and large numbers of confounding variables which affect responses. This section presents some conclusions about children's responses to victimization and the implications of these for prevention and treatment. Because the literature on child victims is so diverse, includes many nonrepresentative samples,

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\* The literature reviewed excluded research on incest and other sexual abuse by family members. This subject was excluded because its dimensions differ substantially from other child victimization experiences; e.g., usually sexual contact extends over a period of years, is not violent (DeJong et al., 1983), and confounds the child's caretaker with the role of victimizer. Because it is a complex literature in and of itself, incest victimization and its sequelae have been covered elsewhere in this book. This literature review covers information from child sexual abuse only when it parallels that found in the child sexual assault literature, where the latter is defined as a one-time sudden occurrence by an unknown assailant using force or threat (Gingrich & Barnette, 1983).



and is filled with gaps in terms of populations and problems studied, the conclusions will also be based on generalizations from the overall child development theory and literature previously discussed.

### *Severity of Problems by Age*

At the present time, there is insufficient evidence of any type as to whether children versus adults who are victims have more problems or more severe trauma. No studies have compared adults to children on a comprehensive and identical set of dimensions and measures. The evidence on whether or not postvictimization problems in children increase with age is contradictory. Only four studies were identified that contained this type of analysis—three of the four involved disasters. The Buffalo Creek study of a flood disaster (Gleser et al., 1981) found disturbance increasing linearly with age; DeJong et al. (1982a, 1982b) reported that psychological trauma increased with age in child sexual assault cases studied; an Australian study of cyclone victims found decreases in problems with age (Milne, 1977); and another study of flood victims (Ollendick & Hoffman, 1982) found no age differences. It should be noted that these four studies were not truly comprehensive in studying problem reactions and trauma; i.e., reactions studied were not those identified as most typical of victims, e.g., shame, subjugation, defilement, resignation (Ochberg, 1984; Ochberg & Fojtik-Stroud, 1982), or manifestations of underlying problems that may prove common in children, e.g., somatic distress, use of fantasy, restitutive play behavior, intellectualization, and so forth. Other than these four, literature reports on child victims involved only one age range or did not differentiate children's reactions by age. Thus, at the present time, the question as to whether severity of victim reactions differs by age (e.g., from preschoolers to adults) remains unresolved.

### *Types of Problems by Age*

What can be approached in the existing literature is the perhaps more meaningful question of the difference in how types of responses differ according to the child's age. Victim reactions by developmental level seem to strongly parallel the research literature on childhood mourning and age differences in defense mechanisms and fears. These conclusions are summarized in Table 1.



Children of all ages seem to show increases in fears and worries, although the content of their fears may be related to age. Younger children may be most fearful of the particular elements associated with their victim experience, e.g., storms in the flood disaster (Ollendick & Hoffman, 1982), going to school or going out of the house (for children whose schoolmates were injured when a skywalk they were on collapsed on their way to school; Blom, 1981), bus travel (two brothers who escaped from an Israeli bus taken over by Arab terrorists, after witnessing the murder of their parents; Dreman & Cohen, 1982), motor vehicles and strangers (26 children kidnapped from a schoolbus in Chowchilla, California, driven around in vans for 11 hours without food or bathroom breaks, and subsequently buried underground in a truck trailer for 16 hours; Terr, 1979, 1981, 1983), and so forth. Sometimes these fears become generalized to items peripherally related to the victim experience, e.g., the dark, loud noises, etc. (Blom, 1981; Eth & Pynoos, 1984a; Gleser, et al., 1981; Pruett, 1977, 1984), or to situations that produce the same feelings experienced during the victimization, e.g., breathing

TABLE 1  
Summary of Common Victim Reactions by Age Grouping

	Preschool	School Age	Adolescent
Fears and worries	X	X	X
Somatic problems	X	X	
Restitutive play, compulsions	X	X	
Regression and separation anxiety	X	X	
Nightmares and sleep disturbances	X	X	X
Fantasies		X	X
Anger, hostility, belligerence		X	X
Interpersonal problems		X	X
School phobias and other school problems		X	X
Apathy, withdrawal			X
Guilt, moral development		X	X
Personality change			X
Chronic sadness and depression		X	X
Self-deprecation		X	X
Intellectualization, including rationalization			X
Anxiety			X
Acting out			X



problems (Terr, 1979, 1981, 1983), concerns over physical safety (Eth & Pynoos, 1984b), etc. Nightmares and sleep disturbances also seemed to span age ranges, although there may be some age differences in subtypes, with younger children reporting exact repetition dreams and nightmares of their own deaths, with older children's dreams having more variations and disguise components (Terr, 1979, 1981, 1983).

Somatic problems appear to be more common in younger children. The cases suggest that the form of many symptoms relates directly to the trauma experienced, e.g., eating disorders in assaults involving oral sex (Katan, 1973), bladder problems for children in the Chowchilla kidnapping incident who experienced incontinence during the 11-hour ordeal in the vans (Terr, 1979, 1981, 1983). Regression and separation anxiety are also reported more for younger children (Fields, 1977; Gleser, et al., 1981; Pruett, 1977, 1984). These reactions are undoubtedly increased to an unknown degree by loss experiences which were frequently associated with psychic trauma in the cases presented.

Restitutive play and compulsions are also more likely to be seen in preschool and school-age children. Pruett (1977, 1984) reported on a six-year follow-up of two children who witnessed the shotgun murder of their mother by their father and his subsequent suicide attempt. When these victim witnesses were toddlers, their restitutive play was viewed as a positive reaction, reflecting the children's attempts at active mastery and control. However, by age nine, repetitive play no longer provided relief. According to Terr (1979), the repetitious play behaviors of the Chowchilla children were destructive, served only to increase their anxieties, and had to be stopped. Perhaps, as she suggests, play behaviors are effective only when the child has a belief, based on past experience, that mastery of the events can be achieved.

A number of reactions seem to be more characteristic of school-age or adolescent children. Guilt is one such area, probably because younger children have not yet reached the necessary superego or moral development stages. There is the suggestion from some cases that trauma may permanently fixate a child at a lower moral development stage (Fields, 1973, 1977). Anger, hostility, and belligerence are more frequently displayed in older children, as well as interpersonal problems, self-deprecation, and chronic sadness and depression (Eth & Pynoos, 1984b; Gleser et al., 1981; Katan, 1973; Klein, 1974; Ollendick & Hoffman, 1982). These may reflect the greater emotionality of older children and their tendency to direct this outward in blaming others or inward toward the self. Effects on the child's performance are also likely to be seen at later ages (Gleser et al., 1981; Pruett, 1977, 1984;



Smietanka, 1984), although this may be because these children are in school and a performance decrement is more readily identified in this structured setting. Fantasies are also much more prominent in older children (Eth & Pynoos, 1984b; Mussen et al., 1974; Terr, 1979), undoubtedly reflecting their increased cognitive development. Some fantasies were more limited and predictable, e.g., imagining vengeance against the victimizer; others involved more major distortions which could significantly affect the child's credibility as a witness, e.g., imagining that the father was the sexual abuser instead of an adult acquaintance (Katan, 1973), or imagining there were three rather than four kidnappers in the Chowchilla bus incident (Terr, 1979, 1981, 1983). Fantasy behavior might be interpreted as the schoolchild's cognitive equivalent of restitutive play as a mechanism to achieve mastery (Mowbray, 1980; Terr, 1979).

Finally, some symptoms appear to be most often found in later developmental stages. Intellectualization, including rationalization, was prominent in this regard. Terr (1979, 1981, 1983) reported that many children aged 9 to 14 constructed "omens" after the incident. That is, in an apparent effort to attain cognitive mastery over the trauma, they attempted to identify prior events (sometimes erroneously) that, if known, would have enabled them to avoid the kidnapping. In Pruett's cases of children witnessing their mother's murder (1977, 1984), rationalization (evidenced through distortions in recounting the violent incident) was seen only in the male child at an older age. This probably reflects an older child's greater cognitive capacity and abilities in abstract thinking. Intellectualizations also describe some children who seemed to be pressured to repeatedly tell the story of the psychic trauma (Terr, 1979, 1981, 1983). This may represent attempts to disclaim responsibility for the event and thereby decrease the guilt and blame experienced. Thus, intellectualization may reflect the older children's increased moral development.

Older children were also noted to display more severe behavioral and performance disturbances: personality changes, acting out, apathy and withdrawal, and anxiety (Eth & Pynoos, 1984b; Gleser et al., 1981; Terr, 1979, 1981, 1983). One possible explanation for this age effect may be that most older children are generally able to manage psychic trauma in ways similar to those of adults—which do not bring them to the attention of others as in need of treatment. Children who cannot handle psychic trauma "normally" at this age are those who have multiple or past problems, so that their reactions are more likely to be markedly disturbed and disturbing to others. And these are the children who get written up as case studies.



Regression and denial are victim reactions that have not been included in Table I, since there is disagreement in the literature as to whether this has occurred in the children studied. Terr concluded that this was not in evidence in her traumatized children (1979, 1981, 1983). Although these children may have repressed their emotional responses to the kidnapping or may not have wanted to talk about it, they did not repress or deny the event occurring or any of the details. Pruett (1977, 1984) indicates that, at least where object loss is involved, such behavior is dangerous because it implies repressing the internalization of the beloved object into nonexistence.

## CONCLUSIONS

### *Relationship of Child Victim Problems to Adult Victim Trauma*

Ochberg (1984) has identified the symptoms most often seen in adult victim trauma (based on the literature and extensive personal experience). Few of these symptoms are seen to any extent in the child victim cases reviewed. *Shame* was reported in several cases, and *self-blame* (including guilt and depression) was commonly reported, at least in older children. *Defilement and sexual inhibition*, although not of a severe or traumatic nature, were reported for some adolescent sexual assault victims (Gruber et al., 1982). More commonly, deviant sexual orientations in children following sexual assault were in the other direction: precocious sexuality, sexual acting out, and promiscuity (Katan, 1973; Smietanka, 1984). The only reports of *paradoxical gratitude* were from child concentration camp survivors who displayed identification with the aggressor and hostility toward their weak caretakers for not protecting them (Klein, 1974). Perhaps the other cases studied did not include associations with the victimizers that were close enough or over a long enough time period for this to occur. *Resignation* is seen in adolescents through reports of apathy, withdrawal, and decreased motivation in school. Other trauma features of *subjugation* and *morbid hatred* were not found at all in these child cases.

### *Treatment Implications*

An early, comprehensive assessment appears to be helpful and necessary for post-trauma adjustment (Eth & Pynoos, 1984a; Smietanka,



1984; Terr, 1979, 1981, 1983). Ideally, this should be within hours and at most within weeks of occurrence. The assessment should be carried out by a trained professional, sensitive to victim issues and skilled in clinical work with children. If criminal victimization issues are involved, the assessor should be experienced in the area of giving and taking legal testimony, so as not to lead the child or bias future legal proceedings (Gingrich & Barnette, 1983). The interview should also be taped and be as comprehensive as possible. Whether or not there are legal implications, the assessment should begin by comforting the child and initiating conversation on a topic that is nonthreatening, but one which will enable an entry into the victimization experience. Children should be asked "what," "when," and "where" questions and be allowed to proceed at their own pace. They should be assured they were not to blame, and they should *always* be believed.

In many children the trauma is displayed as bland affect, disguised with somatic problems, or acted out in play behaviors. Because of these facts and because parents are often disturbed themselves by events and do not like to acknowledge possible child psychopathology, victimized children are rarely brought in for counseling or assessment at this early stage. Thus, assuring an early comprehensive assessment should be a standard service offered by an ongoing service system, such as criminal justice, the medical community, or social services, or perhaps through a specialized victim assistance program. Through whatever structure in the human service system, a debriefing and assessment of the child's psychological problems, offering understanding, and determining risk status for post-traumatic stress, should be available to all child victims. Also, at the early stages of postvictimization, it is critical that the child's family structure be maintained and that the child be returned to his/her usual environment as soon as possible. If, for some reason, this cannot be achieved, then at least the child should be placed in an environment that will provide security and allow new attachments and love relationships to develop.

Every child victim should optimally be subject to follow-up at two and four weeks post-trauma. If resource constraints prohibit this, then those children assessed as being "at risk" must at least be contacted. Limiting contacts to at-risk groups is far from desirable, though, since the literature indicates that *many* children who are victimized, especially when criminal acts are involved, need some type of follow-up and short-term treatment, and our ability to accurately identify those most at risk is severely limited. However, if risk factors are utilized, the following conditions seem to be most associated with later problems:



- The child experiences the loss of a significant attachment figure;
- The parents' (or significant others') reactions are extremely disturbed;
- The caretaker's parenting abilities are disrupted;
- The family atmosphere is chaotic, nonsupportive, or violent;
- The child is physically hurt;
- The child has been previously victimized or traumatized or experienced emotional disturbance;
- The trauma was prolonged or involved multiple episodes or was not acknowledged until much later.

In order to better assess these risk factors and to decrease the possibilities of future traumatic reactions for all children, parents (and often significant others like school personnel) should be counseled as to how to deal with the child, how to answer his/her questions, how to handle their own emotional responses, and what to look for as short-term or long-term symptoms or early warning signals of distress. If, on follow-up contact, the child presents himself/herself as significantly disturbed or the caretaker is significantly disturbed or unable to handle his/her parenting responsibilities, then long-term therapy is probably advisable.

The nature of the long-term therapy is less clear. Individual therapy, family therapy, or parental therapy should all be considered; the choice of one therapeutic approach or a combination seems to be a clinical issue, dependent on the individual case and family circumstances. In most cases of long-term therapy, the following issues need to be addressed (Raphael, 1975; Smietanka, 1984):

1. Helping the child face the truth of what has happened;
2. Dealing with the "damaged goods syndrome"—poor self-image, avoidance of interpersonal relations, etc.;
3. Identifying guilt and self-blame;
4. Dealing with emotions like anger, grief, and fear and how these may be expressed.
5. Helping the child to identify and access supportive resources, e.g., who can he/she trust and how can he/she protect him/herself in the future?

In addition, child victims of sexual assault may often need assistance with confused sexuality, e.g., how to interpret and deal with pleasurable feelings they may have experienced, their need to feel "clean," or their



need to assert power and dominance. Cases of homosexual assault may be even more confusing to children.

*"The Second Wound"*

None of the cases reported demonstrate a "second wound" delivered by the criminal justice system, as is the case with much of the adult literature of criminal victims. However, case studies contain some implications and suggestions for how children should be handled in criminal proceedings. The first issue is to minimize trauma in assessments (as previously discussed). In courtroom proceedings, trauma can be minimized by allowing frequent breaks for child witnesses to rest, get reassurance, or go to the bathroom. There should be a greater allowance for children to recount their experiences at their own pace, including whatever is relevant to them. Otherwise, children may become demoralized or withdrawn (Fisher, 1982). The courtroom setting can be modified to exclude spectators and seating rearranged so that the child does not face the defendant. In some states, legislation has been enacted to allow videotaped presentations from child witnesses. In fact, such changes were recommended by the recent Attorney General's Task Force on Family Violence (Cunningham, 1985). The judge can intervene in direct cross-examination to protect the child and assure that questions are appropriate to the child's developmental stage. Use of a child advocate to familiarize the child with the setting and proceedings, advise the prosecutor and the trial judge, and reduce the child's anxiety at trial may be a very helpful resource to the child and to the outcome of the legal proceedings (Eth & Pynoos, 1984b; NOVA, 1984).

A child's statement should almost always be believed. This dictum is reinforced by every clinical presentation on child victims. Children may lie about not experiencing a victimizing incident, but the reverse is rarely reported. However, as was seen in several of the case studies, children may employ fantasy or rationalization to the extent that important aspects of the traumatic experience or the sequence of events surrounding it suffer major distortions (even to the extent of significant characteristics of the perpetrators). Because of this, it is desirable to have an expert witness available to explain relevant issues in child development and post-traumatic stress and to interpret the child's testimony to the court.



*Prevention*

From the case studies reviewed, two other areas of concern emerged which are not usually considered in the literature on victim treatment, in that they concern primary prevention: avoiding problems of post-traumatic stress. The first area emerged from studies of adult Holocaust survivors (Russell, 1980). Although their children had suffered no victimization themselves, they were still severely disturbed because of their parents' experiences, expectations, and difficulties in parenting. Therapists who treat adult victims need to be particularly concerned about aftereffects on the victim's children, future children, or future generations. When a patient victim has children, a family therapy approach may be warranted or a cotherapy team of adult and child clinicians.

Second, in several cases, it was striking to note the extent of disturbances in children who associated with child victims but were not victimized themselves (e.g., schoolmates of those injured in the skywalk accident [Blom, 1981] or kidnapped in the Chowchilla bus incident [Terr, 1979, 1981, 1983]). Terr (reported in Fisher, 1984) has pointed out that not only do child victims show fears of the supernatural, but that these "hauntings" can be "caught" by others unrelated to the incident because of the highly contagious nature of post-traumatic symptomatology. Perhaps this is more prevalent in children because of their greater vulnerability, because they have less ability to rationalize their own fears ("I'm different from the victim"), less tendency to blame the victim, or because they are more egocentric. Terr comments that children are particularly sensitive to other's anxieties. Whatever the cause, this is an important issue for clinicians concerned with victimization to address. In any case where a child or children have been so victimized (criminally or owing to a disaster) that their experiences and outcomes are given widespread media exposure, interventions with their family, school, and other significant aspects of their environment should be considered. Blom (1981) and Eth and Pynoos (1984a, 1984b) offer consultation models using the school as a focus. The first step in consultation is immediate contact with school personnel, by a clinical team, to discuss the situation, help the staff deal with their own reactions, and plan the intervention. The intervention may include parent education and support group meetings, information collection to identify the overall extent of disturbance and particular problem families or



children, as well as direct interventions with classrooms of children to get them to identify their feelings and concerns and to answer questions.

## SUMMARY

This chapter has presented information available on child victims from the literature, as well as relevant concepts from child development theory and research. The conclusions that have been drawn regarding the type and extent of trauma experienced by child victims and the suggestions for effective interventions should be regarded as highly tentative because of the limitations on the information available. However, even limited the literature, though, there is enough of it to strongly indicate that substantial problems may be experienced by child victims with immediate and long-term reactions to merit concern. Certainly, our general knowledge of child development theory and research substantiates these concerns: children are likely to experience at least as much trauma as adults and probably more, because of their dependency and limited understanding. And their reactions should be expected to differ from those of adults. Although we cannot find definitive answers concerning child victims, perhaps the strongest contribution of clinicians at this point will be to expand their awareness of the special problems of children who are victims and build up a knowledge base for the future which will eventually lead us toward optimum interventions.

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# *The Homicide of a Child*

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Sometimes the most accurate and sensitive appreciation of our patient's inner state resonates from our own unspoken response to his difficulty. As a clinician I have been touched by the particular agony of the parent who has lost a child. It is so painful an empathic experience that I am often struggling with my own tears. I remember leading a therapy group in which a young couple were struggling with acceptance of the death of their five-year-old son. The husband, who was angrily trying to protect his wife and himself from the unresolved grief, demanded some external definition by asking, "How long will it take us to get over this?" An older group member confided, "I'm not sure; it's only been 18 years since my son died, but I don't think you can run away from it or rush through it."

## RELEVANT RESEARCH

Psychiatric research has demonstrated that the death of a child and the death of an adult are followed by bereavement responses that have descriptive similarity (Bowlby, 1980). This correspondence is presumably a reflection of the commonality of affectional bonding between adult-adult and adult-child, but does not convey or illuminate the crucial differences. The intense relationship of attachment between parent and child is unduly sensitive to threatened or real interruption. Parents identify with the vulnerability, helplessness, and innocence of their



child and respond with attention and protection. The reflexive distress, crying, searching, and protest behaviors stimulated by separation are poignant in their immediacy and depth (Edelstein, 1984). It is presumably this fundamental uniqueness of attachment between parent and child that promotes a relational substrate of intense and enduring need and distress with loss—whatever the age of the child (Wass & Corr, 1984).

Psychiatric studies dealing with the effects of a dying child on parents and family have focused on children with terminal illness (Binger et al., 1969; Chodoff et al., 1964). From the prospective observations of these families and their anticipatory and postbereavement responses, it has been established that they are at high risk for development of emotional disturbances. In half the families at least one family member required psychiatric help. Isolation of affect, denial, and increased motor activity were the most commonly observed defenses. The nature of the dying allowed time for psychological acceptance of death through periodic opportunities to ventilate sadness, rage, and guilt, and a partial deathec process of mutual farewell between the parents and child.

While the quality of the relationship between the child, parent, and other family members is an important contributant to the form and course of bereavement, so too is the duration of dying. When death is preceded by a serious prolonged illness, family members may show an increased psychiatric morbidity *before* the actual death. The bereavement with death that is sudden and unanticipated might be more painful and prolonged because of the absence of anticipatory bereavement. Lundin (1984) tested and validated this assumption by demonstrating a significant increase in the psychiatric morbidity of relatives bereaved by sudden and unexpected death when compared with a control group of relatives bereaved by a death that was expected.

## BEREAVEMENT AFTER HOMICIDE OF A CHILD

The nature and course of bereavement after the homicide of a child is complicated not only by its object (the child) and its occurrence (sudden and unanticipated) but by its traumatic mode. The manner of dying determines the meaning of death. With murder, dying is both violent and transgressive. The dying is a brutal, purposeful assault forced on an unwilling victim. The resultant bereavement must somehow embrace these elements of dying that invoke personal terror and social censure. It seems overwhelming—not only to accept the sudden death



of a child, but to be devastated by the terror and brutality of a senseless killing. We might take for granted the psychological stability of parents and family members, who somehow cope with this synergism of tragedy. The quiet courage and resolute optimism that are normally maintained are a marvel to me and represent a resiliency we should celebrate and try to understand.

The dying is a widely publicized event, placing the bereaved family members in an intense focus of social scrutiny. The bereaved are forced to cope with the socially demanded processes of investigation, apprehension, trial, and retribution. These social and legal imperatives necessarily divert attention and energy from the primary substitute task for process of bereavement.

Preliminary and anecdotal research findings describing the effects of homicide on bereavement have included the murder of children (Burgess, 1975; Lehrman, 1956; Rynearson, 1984; Sheskin & Wallace, 1976). How one defines "child" must be relatively arbitrary, since that assignation will always be applied by parents and older extended family members of the victim. They all shared in varying degrees the intense attachment bonding during the victim's childhood, which remains internalized no matter the age of the victim. When the victim's immaturity has not allowed physical and emotional separation from the family unit, which in our culture has not been established until late adolescence, then the victim is in an active, mutually accepted role of "child." The traumatic loss of this developmentally intense and vulnerable attachment with a child is followed by a painful and prolonged syndrome of readjustment. Although this syndrome has a strong empirical foundation, we cannot cite systematic, rigorously controlled data that would allow quantitative statements. At this stage of investigation, clinical research has suggested its differentiation from other forms of bereavement on the basis of descriptive signs and symptoms, without a firm explanatory theoretical model. Specific reactions of affect (fear and rage), cognition (intrusive images of homicidal dying), and behaviors (hypervigilance, startle responses, avoidance of violence, and retribution) present with bereavement after a homicidal loss as epiphenomena of the act of homicide. The specific reactions commonly last one to two years.

#### *Affects*

In addition to the affects commonly associated with bereavement (sadness, anxiety, and guilt), there are affects that are apparently related to the violence of the death. A pervasive fear begins with awareness



of the murder and lasts for several years. Anger is another invariable affect associated with homicide. The bereaved views the homicide as a purposeful, unwarranted act that by its commission characterizes the murderer as deserving of censure and retaliation. A deep and justified anger toward the murderer might diminish after 12 to 18 months (sometimes coincident with trial and punishment), but it never disappears.

### *Cognitions*

The presence of intrusive, repetitive images of the homicidal dying appear as "flashbacks." The images focus on the terror and helplessness of the victim during the last minutes of his life. The unbidden images of homicide are so central that they interfere with other cognitive operations. Concentration and thought sequencing are disrupted for 6 to 18 months. These images also emerge during sleep. Vivid recurring nightmares of the murder are common, as are conscious fantasies and nightmares in which the bereaved are murdering the murderer.

### *Behaviors*

There is an invariable heightened anticipation and protective avoidance of violence. Hypervigilance and startle reactions last 6 to 12 months following a homicide. Compulsive behaviors of self-protection are so intense during the first year of bereavement that the subject's usual range of territorial and affiliative behaviors is constricted. Unfamiliar surroundings are circumvented. Home becomes a protective fortress. Strangers are avoided, and there is a compulsive need for the proximity and tangible assurance of safety of remaining family members. Behaviors directed toward retribution are also common. They begin with cooperative efforts with police to investigate the murder and to apprehend the murderer. Later there is direct involvement in judicial acts that promise justice and punishment.

The specific epiphenomena of homicide upon bereavement are not explained by long-accepted psychological models (Rynearson, 1986). Delayed deatthexis, repression of ambivalence, denial of death wish, and pathological identification will not serve as explanatory principles for these variant signs and symptoms. A more inclusive psychological model would serve better. Such models have been developed for clinical populations who have been exposed to horrific, life-threatening situations that they have survived.



### *Psychological Trauma*

Post-traumatic stress disorder describes psychological reactions to trauma consisting of hyperreactivity (startle reactions, explosive outbursts of anger) and recurrent intrusive recollections of the trauma (flashbacks, nightmares), alternating with a compensatory psychic numbing, constriction of affect and social functioning, and a loss of a sense of control over one's destiny (Krystal, 1974; van der Kolk, 1984). The traumatic stressor is here defined as an aversive stimulus that mobilizes so much painful affect that psychological adaptive mechanisms are overwhelmed, initiating the alternating responses of hyperreactivity and hyporeactivity. Homicide, with its volition, violence, and suddenness, certainly qualifies as a traumatic stressor.

### *Victimization*

This clinical reaction occurs with individuals who are deliberately harmed or coerced by another human being. The growing literature on victimization was reviewed by Ochberg (1984), who proposed a clinical definition: "The core concept and definition of victimization is a physical assault or threat of assault in which physical damage or violation occurs accompanied by a sense on the part of the victim of reduction in dominance and concomitant resignation or rage or both" (p. 13). Physical assault or threat of assault is accompanied by post-traumatic stress reaction plus a residual attitude of resignation and/or rage. Victims commonly experience humiliation, isolation, worthlessness, compensatory hatred, and obsessions of vengeance. Ochberg notes that "many people identify with victims although they are not literally assaulted themselves" (p. 13). This is a common finding in individuals who are bereaved through homicide, who now feel themselves victimized.

### *Grotesque Death Imagery*

Lifton (1976), in his work with Hiroshima survivors, noted a persistence of intense preoccupation with the mental images of mass death that these survivors were forced to witness. This imagery contributed to a dreaded fear of their own dying in stark unnatural terms. Homicide is not only grotesque in the reality of its violence and volition, but may be mutilative as well. This death imagery is intense and frightening in individuals who have lost a relative through homicide, though they never witnessed the trauma directly or viewed the body. Because of



their psychological attachment they are left to work through an internalized fantasy of grotesque dying.

### *Despair*

The homicidal form of dying dispels the comforting belief that there is protection from violence and inhumanity. Death in this instance is not "fair" or peacefully accepted. It does not conform with the schema of natural events that was anticipated for the deceased. This is reinforced by the investigative and judicial institutions of our society, which force the bereaved to seek explanation and/or retribution. Neither explanation nor retribution will restore the protective illusion of safety (Rynearson, 1981).

These models better explain the affective, cognitive, and behavioral sequelae of homicide on bereavement and provide a basis for therapeutic strategies.

### CASE ILLUSTRATIONS

I write primarily as a clinician interested in the treatment of individuals and their families. At last count, I have cared for various family members struggling with the homicidal loss of over 20 children. The tabular and statistical generalizations of this work would not contain the relevant descriptive and therapeutic details. Rather, I shall present case reports of three separate families who were traumatized by the murder of a child. Each highlights a separate facet of homicidal dying that influences the bereavement and the therapeutic approach.

#### *Case 1*

Marci was 10 at the time she was killed. She was an only child who was highly treasured by both of her parents. Her early childhood was complicated by a congenital back defect that required multiple hospitalizations, surgeries, and uncounted hours of physical therapy, which her parents helped to supervise at home. They remembered her as a smiling, courageous, optimistic child who had tangibly mastered her handicap. She had joined a children's swimming team that summer, and as she was waiting for her parents after a practice session, a young, disheveled, delirious man stabbed her to death. The murderer was immediately apprehended. He previously had been committed for treat-



ment of paranoid schizophrenia. He had been abusing street drugs the weeks before the murder and claimed he was amnesic for hours before and after the killing.

The father never openly wept or mourned. He stoically supported his wife during her bereavement. The murderer's trial and sentencing became a daily preoccupation for him. When the murderer was committed to a locked forensic ward, the father continued to create pressure through the press and legislature to ensure "that he would never walk the streets again." Four years later, when the murderer was released in spite of the father's impassioned and enraged protest, the father became fearful "that he will kill again," and more specifically, "that he will come after me now." He began having vivid recurring nightmares of his daughter's dying and sought treatment for his insomnia. He was treated on a weekly basis and encouraged to ventilate and accept his long-suppressed mourning. He remained focused on his rage and frustrated demands for retribution, which were acknowledged but interpreted as somehow defensive—that this allowed him to remain assertive and externally focused to avoid his internalized sadness and helplessness. As he allowed himself to mourn and surrender his daughter's image, he also surrendered the image of himself as the protective, caring figure who would overcome his daughter's death as if it were another handicap rather than a finality.

*Comment.* This case highlights the unconscious persistence of caregiving role expectations following the homicide of a child. Retribution can serve as a protective displacement of unresolved bereavement. When retribution no longer serves its defensive purpose, the suppressed bereavement more clearly emerges and can finally be worked through and assimilated.

## *Case 2*

Andrew killed his father and his 13-year-old sister with a shotgun and then notified the police. His paranoid schizophrenia had been manifest for several years. During the intervals when he was intensely delusional and frightened, he had threatened his parents and four siblings. Though frightened, the family somehow accommodated to his unpredictable threats, but they no longer accepted him with warmth or trust. The killing was a dreaded threat that the family had shared in denying. I eventually interviewed all the remaining family members, but it was the mother who first consulted me, months after the murder.



She was terrified and enraged. She and her younger son and daughter remained in the house where the murder had occurred, and she insisted that her older son, who had moved away, phone her at least twice a day to verify his safety. She installed heavy locks and bars in the windows and doors and armed herself.

Therapy was stymied by the discrepant image of her own son, who was now a murderer—an image that could not contain her dissonant feelings of sadness, guilt, rage, and fear. The urge for retribution was opposed by her urge to ensure that he was cared for. Underlying this confounding mixture of feelings was her conviction that she should somehow have prevented this tragedy—that her husband and daughter would still be alive if she had fulfilled her responsibility as wife and mother.

The family slowly disintegrated as a unit. Subsequent reunions at holidays were a heavy, unspoken renewal of the fear and guilt they shared. Years later, these intense aftereffects of the murder subsided so the family members felt secure enough to separate in order to resurrect their own individual futures. At this time, each has moved to a different city, and the son who committed the murder has been released from the hospital and has moved back into the family home.

*Comment.* When homicide occurs as an intrafamily crime (as it does in 18% of homicides), there is a resultant dilemma of identification for the remaining family members. The bereaved identify not only with the victim, but with the murderer as well. Rage and retribution are particularly ambivalent reactions to resolve. The caregiving role expectations following the death of a child in the situation of intrafamily homicide involve the murderer as well.

### Case 3

Sherry was 13 at the time of her disappearance. The year before, there had been a dramatic shift in her attitude and behavior. She became defiant and oppositional toward her parents. She refused to stay at home or remain in school. Her family remained committed, asking her to return, while forced to accept their impotence in maintaining a caring interchange.

The family became increasingly apprehensive as weeks passed without word from her. When she failed to call her younger brother on his birthday, her parents notified the police. Her disappearance was no longer accepted as voluntary. She was now considered a victim of a



serial killer who had systematically murdered young female prostitutes. The family was unwilling to accept that horrible and stigmatized possibility. Her mother felt that so long as they had not found her remains there was still "hope" that the girl was alive. The mother maintained a daily search and enlisted the help of her daughter's friends to widen its scope. The disappearance was broadcast nationally through the newly formed Bureau for Missing Children. So long as the grim possibility of her murder could not be tangibly confirmed, the family clung to the hopeful possibility that she was still alive.

The mother considered her therapy a clandestine opportunity to ventilate her bereavement and fear that her daughter had in fact been murdered, which she and other family members colluded in hiding from one another. The daughter has not yet reappeared, and the family remains hopeful that she is still alive.

*Comment.* The disappearance of a child is followed by an intense search, which is maintained by family members long after others abandon hope. This compulsion is an enduring, caregiving behavior which cannot be suppressed or refuted and delays the acceptance of the finality of loss and the fear of homicide.

## TREATMENT IMPLICATIONS

The conceptual model of bereavement after homicide here presented suggests the psychological state of collapse rather than conflict. The clinician will find the dynamic concepts of adult catastrophic responses more relevant than the more familiar model of infantile trauma and conflict. Such a model based on catastrophic loss considers not only bereavement but the overwhelming trauma of homicide. The reality of homicide is so fundamentally frightening and abhorrent that the bereaved cannot assimilate the resultant painful affects. The traumatic interruption of the psychological bonding with the child intensifies the pain of the loss and horror. The bereaved family member is left with an internalized image of homicidal dying that includes lethal violence and transgression. Bereavement thus prescribes an identificatory reenactment and psychological adaptation of a traumatic death which is only rarely witnessed. It is the bereaved rather than the victim who presents with post-traumatic affects (fear and rage), cognitions (intrusive images), and behaviors (hypervigilance, startle responses, avoidance of violence, and retribution). The traumatic interruption of bonding with



the murdered child leaves the bereaved with persistent caregiving role assumptions (proximity, nurturance, searching, protectiveness), which prolong and intensify deathea.

The clinical sequelae reportedly last for years. They might therefore be misinterpreted as reflection of pathological grief. This misdiagnosis would misdirect the therapist to insist on a previous ambivalent attachment with the child. Although ambivalence may have existed, its presence does not necessarily serve an explanatory or therapeutic purpose.

Therapy strategies for this form of bereavement are necessarily presumptive, since there is no controlled prospective study to establish effectiveness. It follows from our conceptual model of traumatic bereavement that the techniques of support and modulation should be included:

1. *Supporting the assimilation of traumatic death.* An appreciation of the bereaved's capacity in accepting previous deaths or losses will clarify the direction and course of subsequent bereavement. Resolution will include a particularized approach and sometimes avoidance of the internalized traumatic death. The therapist will follow the survivor's restorative vector, supporting and reinforcing mechanisms, that have allowed assimilation of death and loss in the past. Knowing the bereaved's previous experience with death or loss creates an experiential substrate of bereavement which will illuminate the essential differentiation of traumatic bereavement. Post-traumatic reactions and responses of grotesque death imagery, victimization, and despair may then be explored and appreciated as distinct psychological reactions to homicide. Understanding the natural course of bereavement and the sequelae of homicide allows the patient a sense of control, anticipation, and direction. A clinical lecture should be avoided, which might inappropriately and prematurely suggest difficulties. However, when the clinician knows the patient well and has established an empathic and trusting relationship, the clinical issues will be interpreted in the context of what is known about bereavement after homicide rather than interpretation of unconscious conflicts or transference.

2. *Modulation.* The feelings, thoughts, and behaviors associated with homicide are overwhelming and not uncommonly lead to dysfunction. During the early phase of adjustment, the therapist should avoid techniques that evoke or suggest abreaction. These ventilatory techniques should be reserved for the later phases of adjustment. Antianxiety and hypnotic medications are often indicated to diminish the common re-



sponses of fearfulness, startle reactions, intrusive death images, and insomnia. Cognitive, behavioral, and stress management techniques may also provide additional modulation. When dysphoria lasts more than two or three months and is accompanied by objective vegetative signs of depression, an antidepressant medication should be prescribed. There is no evidence to suggest that the judicious use of medications distorts or prolongs bereavement.

3. *Complicating variables.* Bereavement is influenced by particular features of homicide: (a) When the child is killed by another family member, a confounding dilemma of identification confronts the entire family (case 2). (b) When the child has disappeared, the acceptance of homicide cannot begin until the body is found or the family tires of searching (case 3). Some families will never stop. (c) When the murder remains unsolved, as it does in 28% of homicides, the bereaved is left with an internalized traumatic dying that remains unbuffered by solution, punishment, retribution, or redemption.

4. *Support groups.* While individual and family therapy are well-established forms of intervention, a support group comprised of members who are themselves adjusting to bereavement after homicide provides a unique opportunity for support (Getzel, 1984). The established members embody the hopeful promise of recovery for new members and share an immediate resonance and empathy with the specific aftereffects of homicide. The group can also guide the new members through the uncharted experiences of public scrutiny with press and television and the investigative and judicial ordeal to come.

Finally, the bereaved will always maintain an attachment to the dead child. It would be a mistaken therapeutic objective to insist on decathexis. Instead, the bereaved will somehow maintain involvement with others while maintaining an internalized relationship with the child's image. Complete recovery from this traumatic form of bereavement would be an unrealistic goal for the patient and therapist. The reassumption of one's former identity and life assumptions is forever lost. This bereavement promises survival and eventual improvement, but the change is dialectic rather than homeostatic.

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## SECTION III

# The Victim of War and Atrocity

The chapters that comprise this section focus our attention on three populations: American veterans of the Vietnam war, survivors and children of survivors of the Nazi concentration camps, and recent refugees from Southeast Asia.

To treat the wounds of these survivors the therapist must understand history and culture as well as psychology. For example, the losses suffered by Jewish victims of Hitler's holocaust included loss of a homeland, a nuclear family, an extended family, personal possessions, and the sense of continuity through time and space. The remarkable resilience of the Jewish people to persecution should not deflect attention from the enormity of state-sanctioned violence against them. Treating individual symptoms of depression, survivor guilt, anhedonia, and alexithymia must be complemented with group therapy that attempts to reconstruct culture, cohesion, trust, and a collective sense of significance. The restoration of personal integrity and Jewish identity are the goals of post-traumatic therapy for this population.

By analogy, the adolescent American soldier in Vietnam endured state-sanctioned carnage and upon return was treated as a pariah by fellow Americans, causing a loss of a sense of homeland, family, and culture. But the perspective of the young soldier is understandably different than that of the Jewish death-camp survivor. The process of optimum reacculturation is different; the pattern of post-traumatic disorder is different. Soldiers were trained to take action when aroused beyond the threshold of anxiety in life-threatening situations. For some, the activation of the sympathetic nervous system still produces reflex



movement, either aggressive or evasive. Clearly, these battlefield reflexes are inappropriate in civilian life. By contrast, untrained persons threatened with death in captivity are more likely to find their emotional and behavioral reactions blunted or ablated. And this extreme under-reactivity may be passed by parents to the next generation.

John Wilson, writing about his work with Vietnam veterans, describes analogous, but distinctly different, therapy programs, including a Native American sweat lodge ceremony that has intriguing relevance for his survivor population. Yael Danieli, writing about her work with holocaust survivors, describes ritualized therapy programs that promote individual and group actualization. Both authors have, through decades of first-hand experience, learned the language of the populations they treat and developed models of therapy based on appreciation of history, culture, and psychology.

John P. Wilson founded the Forgotten Warrior Project on Vietnam Veterans in 1974, then helped design and implement both the Disabled American Veterans and Veterans Administration readjustment counseling programs. His research interests include the study of Pearl Harbor survivors and Native American healing rituals for war stress.

Yael Danieli served in the Israeli Defense Forces before emigrating to the United States, where she founded the Group Project for Holocaust Survivors and Their Children. Her research explores intergenerational transmission of victimization, heterogeneous adaptational styles, survivor's guilt, and the attitudes and difficulties of mental health professionals working with survivors and children of survivors of the Nazi holocaust.

The final chapter of this section, by Richard F. Mollica, reminds us that war and atrocity continue; the systematic annihilation of a culture through the tyrannic application of death, torture, and forced migration is not only a shadow of the recent past, but part of the enduring present. Although Dr. Mollica concentrates on the tragedy of the Cambodian refugee, he could be writing about Afghanis, Haitians, Ugandans, and any of the two million missing persons and their families who, according to the United Nations, comprise the largest group of victims of political violence in the world.

Dr. Mollica is a psychiatrist, epidemiologist and a graduate of the Yale Divinity School. He has been a Visiting Fulbright Lecturer to the United Kingdom and an epidemiologic consultant to the Italian government. In December, 1981, he founded the Indochinese Psychiatry Clinic at St. Elizabeth's Hospital. On the faculty of Harvard Medical School, he directs the Harvard School of Public Health Program in Refugee Trauma.



## *Understanding the Vietnam Veteran*

JOHN P. WILSON

Wars disrupt the social fabric of a peaceful society. The political, moral, and economic systems that form the tissues of a healthy nation are altered by the demands and exigencies of war. Military conflict leaves a legacy in the psyche of those warriors who later become known as veterans. And although the precise content, nature, and burden of the legacy varies according to the roles and responsibilities of the combatant, it is generally the case that immersion in the grotesque realities of killing and destruction creates a lasting imprint in memory that profoundly alters an individual's sense of humaneness and dignity.

This chapter presents a way of thinking about those who were victimized by their participation in the Vietnam War. By victimized we do not wish to convey the impression that all Vietnam veterans were victims in a traditional sense of being coerced and helpless victims of circumstance. Although one could make such a case, it belies the complexities of the stressors inherent in the Vietnam War. However, victimization as defined by Ochberg in Chapter 1 of this volume includes a sense of humiliation. He writes,

the victim often feels diminished, pushed down in a hierarchy of dominance, exploited, and invaded. These terms describe the act of victimization as much as they describe the ensuing feelings of the victim. . . . Victimization should suggest a transient state of personal disequilibrium, beginning with unanticipated trauma and ending with survivor status or reequilibration. But since we have



so little language to explain victimization and few culturally accepted rituals of support, it becomes the task of the therapist to normalize the process. (p. 11)

Clearly, this definition of victimization applies to many of the veterans of the Vietnam War since they often were rejected, exploited, and pushed down by government and society both during and after the war. Victimization was compounded by denial of adequate benefits, the lack of proper treatment for mental disorders associated with combat, and inadequate educational and vocational benefits. In order to understand this phenomenon more precisely, it is necessary to know something about the nature of the Vietnam War, the typical warrior who fought it, and the unsympathetic environment to which he or she returned on the long road home from Southeast Asia.

#### A COMPREHENSIVE MODEL OF HUMAN ADAPTATION OF TRAUMATIC EVENTS

In recent years scholars and clinicians in the field of victimology have recognized, often tacitly, the necessity of a comprehensive, interactional model of post-traumatic adaptive behavior (Green, Wilson, & Lindy, 1985; Figley, 1985; Horowitz, 1986; Wilson, Smith, & Johnson, 1985; Lazarus, DeLongis, Folkman, & Green, 1985). Building on the earlier models set forth by Kardiner (1959), Niederland (1968), and Horowitz (1976, 1979), these interactional models illustrate how different factors in the *person* (e.g., personality traits, early life experiences, family background, belief system, coping patterns, etc.) interact with *trauma dimensions* (e.g., severity, duration, type of injury, suddenness, etc.) and *societal variables* (e.g., attitude toward victim, support network, rituals of sanction and recovery, etc.) in determining how the stressful life experience gets assimilated into the self-structure. Furthermore, such an interactive model helps one to recognize that while situational variables (e.g., witnessing an atrocity or mutilation) might exert their own unique influence on the post-traumatic processing of the event, these are likely to be moderated by other variables such as the degree of social support in the recovery environment and pre-trauma personality attributes.

Moreover, from both a theoretical and pragmatic aspect, a comprehensive model of human adaptation to extreme stress has several advantages when treating victims. First, it is generic in nature and can



be applied to different traumatic events. Second, it does not presume a particular theory of personality and psychopathology and therefore permits flexibility in gauging how much of the victim's post-traumatic adaptation is determined by character structure, by specific stressors experienced in the trauma, and by the presence or absence of social support. In this regard the model encourages the clinician to look beyond personality factors and psychopathology to understand the nature of the stress recovery process.

It is difficult to listen nonjudgmentally and empathically to the distressed, painful, intense description of traumatic events. Victims have undergone experiences that not only have shattered their illusion of invulnerability and belief in a just world, but may threaten us by opening our eyes to the consequences of brutality, rape, incest, combat, and other forms of man's inhumanity to man. As much as we might want our perspective of life to reflect a vision of decency and morality, victims and survivors teach us that many forms of cruelty and evil confront ordinary people every day. And herein lies one of the paradoxes of clinical work with victims. The greater the willingness of the clinician to be open and nonjudgmental about the traumatic event and its emotional impact on the patient, the more the clinician will confront the struggle with pain, a pain that is a legacy for the victim and for the therapist as well.

As Lifton (1976) and Frankel (1963) have written so eloquently, the task of the victim is to reformulate the meaning of the traumatic experience. Furthermore, as Horowitz (1979) noted, the stress recovery process has an expectable sequence of stages and associated sets of subjective imagery (e.g., rage at the source and fear of repetition). What determines whether or not the individual will find new meaning in life and successfully overcome the distressing images and affects that constitute the post-traumatic syndrome is presumed to be a function of personality styles, the severity of the trauma, and the degree of emotional support.

In summary, a comprehensive model of adaptation to extreme stress takes into account four major elements: (1) the nature of the traumatic event and the unique stressors experienced in it; (2) the personality attributes and coping mechanisms of the individual before, during, and after the trauma; (3) the nature of the recovery environment; and (4) the sequential stages of post-traumatic cognitive processing, which are, in turn, affected by all of the other variables.



## THE NATURE OF STRESSORS IN THE VIETNAM WAR

In recent years, stimulated in part by the recognition of post-traumatic stress disorder (PTSD) as a distinct survivor syndrome with official diagnostic status in DSM-III of the American Psychiatric Association, many books have been published about the stress disorders among Vietnam veterans as well as the special nature of the war itself (e.g., Figley, 1978, 1985; Figley & Leventman, 1980; van der Kolk, 1984; Kelly, 1985; Sonnenberg, Blank, & Talbott, 1985; Hendin & Haas, 1985). For Vietnam veterans the core elements of intrusive imagery are the scenes of death, dying, injury, environmental destruction, chaos, maiming caused by booby traps, repetitive capture and loss of terrain objectives, in a primitive, terrifying environment. More specifically, exposure to war stress includes such diverse experiences as *active* killing of the enemy in firefights in the jungle, search-and-destroy missions, river patrol, mortar bombing, aerial combat assaults from helicopters, hand-to-hand combat, long- and short-range reconnaissance work, and the clandestine operations of special-forces units that involved assassinations, interrogations, and counterinsurgency operations. Furthermore, combat in the Vietnam War also included the *passive* witnessing of the carnage of war in such experiences as *seeing*: (1) enemy, civilian, and Americans dead; (2) atrocities (e.g., mutilation); (3) villages, property, and the earth destroyed by bombs, chemical defoliants; and (4) the deliberate torching of villages. Additionally, combat exposure and war stress also included such experiences as *participating* in (1) the body count of enemy dead; (2) atrocities; (3) helicopter medivac; (4) medical procedures in field hospitals; (5) graves/registration duty (i.e., retrieval and preparation of bodies in "body bags"); and (6) the combat roles and stressors mentioned above.

When attempting to understand the impact of war stress on the soldier, it is necessary to examine the unique features of guerilla warfare, which is characterized by hit-and-run combat tactics, surprise ambushes, the extensive use of booby traps and land mines, as well as the psychological impact of the environmental stressors found in the jungles and rice paddies. *In guerilla warfare unpredictable ambushes lead to a high level of anxiety and hyperarousal in anticipation of the next attack.* More specifically, the unpredictability of events extended to: the location of the enemy; the identity of the enemy in terms of whether villages, farmers, children, women, and the elderly were just that or actually



Viet Cong forces; the location of different types of booby traps; the onset of enemy attacks (incoming mortar, rockets, ambushes, sniper attacks, etc.); the reliability of South Vietnamese military forces; and the repetitive capture and loss of military objectives. Finally, the environmental stressors included functioning in a difficult terrain that was typically hot, wet, rainy, and infested with snakes, leeches, rats, and other species native to Southeast Asia.

There are additional attributes of the Vietnam War which contributed to the development of stress disorders among Vietnam veterans. As Wilson and Krauss (1985) have noted, the one-year tour of duty, in which unit membership was constantly rotating "back home" at different dates, often led to a "survivor mentality" concerned with completing safely the tour of duty rather than subscribing to a clear ideological purpose for fighting the war. Beyond that was the fact that the transition from the war zone to the front porch of home took, on the average, less than 36 hours. In this transition time there was no systematic decompression, psychiatric counseling, or other attempts to help the warrior overcome combat fatigue or general emotional distress. Perhaps even more important from a humanitarian perspective was the absence of cultural rituals of reentry, recognition, and sanction for the veteran's role in the war. There were no victory parades, no homecoming ceremonies, no attempts to honor the actions performed by the veteran in the war.

In this regard it is appropriate to think of Vietnam veterans as victims. They did what they were asked to do by their government and country. Afterward, many became "forgotten warriors" (Wilson, 1978, 1980a). Thus, it is not surprising that many of them felt embittered, angry, used, pawns of the government, exploited, violated, stigmatized, cynical, and alienated. And these were young men: the average combat soldier was 19 years old. The stress of war taxed their ability to form a clear, coherent sense of personal identity; it led to a relentless questioning about the meaning and purpose of life; it often destroyed or changed personal belief and ideological systems; it robbed many of their youth and naiveté; it made profoundly difficult the normal sequence of early adulthood development (e.g., identity, intimacy, generativity); and it made finding a niche in society a doubly demanding responsibility since the war stress often left a distressing psychic legacy, which, in turn, intensified, compounded, and aggravated the stages of psychosocial development (e.g., Wilson, 1980a; Figley & Leventman, 1980; Card, 1983; Wilson, Smith, & Johnson, 1985).



## NORMATIVE IDENTITY DIFFUSION AND PTSD

Since the typical Vietnam combatant was 19 years old, we can ask a very simple and yet important question. How do high levels of combat exposure and war stress impact on the stage-specific tasks of ego development at this point in the life-cycle? To answer this question requires that we know the nature of the normal psychosocial crisis that occurs at this time of late adolescence and the transition years into adulthood. As many clinicians and scholars have noted, the transition into adulthood occurs between the years of 17 to 25 (Erikson, 1968; Levinson, 1978). Typically, this period of ego development contains a number of normative "tasks" that the individual must confront in the process of establishing a coherent and reasonably stable sense of identity and self-esteem. These tasks include: (1) separation from parents; (2) the initial formulation of a career plan; (3) the development of defined patterns of interdependence with others that are congruent with personality dynamics; (4) the process of making *commitments* to initial career and life-style choices; (5) the formulation of a broader sense of ideological perspectives in terms of political, moral, and social issues; and (6) integrating all of the above into an identity structure that has a "sense of continuity and self-sameness through time" (Erikson, 1968) such that future aspirations, hopes, and dreams seem reachable.

However, in the case of Vietnam veterans it has been suggested (Wilson, 1978, 1980a; Wilson, Smith, & Johnson, 1985; Wilson & Krauss, 1985; Haley, 1985) that the *nature* of the Vietnam War (particularly the lack of a clear-cut sense of purpose and the unique war stressors) and the *absence* of ritual welcome, honor, and transformation of the warrior identity into a new set of responsibilities produced widespread identity diffusion among this era of veterans. In this regard one can speak of *normative identity diffusion* since the stressors of war negatively affected the predominant task of identity formation. Normative identity diffusion means that: (1) formulation of career plans was delayed, ignored, or made difficult because of complicating psychological and economic factors; (2) modes of interdependence were not established because of mistrust, fear of closeness, purposeful distantiation, psychic numbing, and emotional constriction; (3) commitments to self, others, and career were rendered difficult because of a confusion in values, ideology, and meaning of the war; and (4) a sense of continuity of the self had been profoundly altered by the war experience. In more concrete and clinical ways these changes in the self-structure are expressed as follows by several of my patients: "I am not the same as before 'Nam; I am



different than I was before I went; I feel like I'm much older now—maybe 50, 60, who knows; I feel like an outsider, I don't fit in; I'm confused about why my buddies died and what it all meant; I think about the 'Nam every day, it was the most important thing I ever did; part of me died in Vietnam, I'm just a walking shell of my former self; I lost my youth and innocence in 'Nam; sometimes I think the lucky ones are still in Vietnam; I wish I could go back to Vietnam, at least it was real; I get so frustrated sometimes, I mean I'm 37 years old and trying to complete college; I wonder if I'll ever get a real job someday; I get tired of the struggle with the VA and everyone else, they don't understand."

Clearly, these and similar statements point toward the fact that among Vietnam veterans the stressors of war and the isolation upon coming home combined, in effect, to intensify and compound the usual tasks of early adulthood. In this way one can see a common dilemma for many of these men and women: the war was the place where their first *adult* responsibilities and "hands-on" job experiences took place. Despite the traumas of war, for many of the 18- to 20-year-olds, Vietnam was real, exciting, intense, adventuresome, and meaningful because of the bonding with others in life-and-death situations. Indeed, *one dimension of stress and adaptation in this population is the strong adherence to the warrior role because that was the core identity which developed at a critical stage of life.* At the deeper levels of consciousness many of these individuals fear that if they let go of being Vietnam veterans they will have nothing left to their souls. In this regard it must be understood that PTSD may be far more than a process of reactive transformation, but rather an integral part of intrapsychic development. Thus, a central task of treatment, after working through the painful and unresolved issues of war stress, is to facilitate the development of a healthy self-concept that can encompass the old self, the 'Nam self, and a newly integrated self.

#### PTSD AMONG VIETNAM VETERANS

As defined in DSM-III and DSM-III-R, PTSD is characterized by involuntary and distressing intrusive images, dissociative states of consciousness, distressing affective flooding, physiological hyperarousal, and unconscious behavioral reenactments of the event. These symptoms represent the complex interplay between the cognitive processing of



the trauma and neurohormonal mechanisms that are both activated and associated with the stress disorder (Chapter 2).

Table 1 presents a summary of the symptoms of PTSD among Vietnam veterans. The symptom clusters are grouped into their common factors as determined by factor analytical studies of the internal structure of PTSD in Vietnam veterans (Wilson & Krauss, 1985). Additionally, each of the symptom clusters is classified according to the revised diagnostic criteria of the third *Diagnostic and Statistical Manual* (DSM-III-R) of the American Psychiatric Association (1987).

The core features of PTSD are shared by many victim populations. However, there are unique features of PTSD in different survivor populations that result from the nature of the stressors in the traumatic event, the person's role in the trauma (e.g., agent or victim), and the nature of the recovery environment. Thus, some of the attributes of PTSD among Vietnam veterans would not be found in veterans of World War II or other victim populations.

## THE DIMENSIONS AND DYNAMICS OF PTSD

### *Depression/Search for Meaning/Identity Confusion*

Among clinicians who have treated Vietnam veterans it is a common observation that depression is a major component of PTSD. Many veterans feel trapped in the trauma and believe that they will never come home from the war. They feel helpless, hopeless, depersonalized, dejected, defeated, and profoundly weary of the struggle to sort out the meaning of the war. Typically, there is unresolved grief and strong feelings of loss. The feeling of loss is deeply rooted in physical, psychological, and social experiences associated with the war. Many men report that they lost their identity, youth, naiveté, and beliefs in God, justice, authority, and the government in Vietnam. As a result there are feelings of confusion, mistrust, and existential despair. Nothing matters anymore. For these men, life is experienced as empty, devoid of any real purpose or meaning. They are only a walking shell of their former selves. Moreover, it is frequently the case that this painful state of depression is accompanied by isolation from others and suicidal imagery. Symbolically, some men "feel dead" at this time or state that whoever they were died in Vietnam and that the lucky ones are on the wall (Vietnam Memorial) in Washington, DC. In cases of PTSD where survivor guilt is associated with depressive states the veteran



TABLE 1  
Symptoms of Post-Traumatic Stress Disorders Among Vietnam Veterans

Symptom Cluster*	DSM-III-R Criteria
I. Depression/search for meaning/identity confusion Helpless, hopeless, dejected, depersonalized, passive, suicidal, isolated, vulnerable, sleep disturbances, emotional constriction, sense of loss, grief, denial, problems of concentration and attention, survivor guilt	D1, 3 C4 Increased arousal Avoidance
II. Anger/rage Fantasies of retaliation, diffuse anger, sense of being used, exploited, a pawn; frustration, short fuse, paranoid ideation	D2 Increased arousal
III. Intrusive imagery/affective flooding Nightmares of war, daytime intrusive, emotional flooding; dissociative states, amnesia, survivor guilt, unconscious reenactment; sleep disturbances	B1, 4 Reexperience
IV. Emotional constriction/avoidance Emotional anesthesia, desexualization, loss of tenderness, psychic numbing, avoidance of crowds and situations that arouse memories of war; problems of concentration	C1, 6 Avoidance
V. Hyperarousal/sensation seeking Excessive autonomic nervous system arousal, hypervigilance, hyperalertness, survivor mode of functioning	D1, 4, 5 B3, 4, 2 Increased arousal Reexperiencing
VI. Stigmatization/alienation Self-conscious as veteran, alienated, mistrust authority, government, sensitive to phoniness, deceit, lies, injustice	C5 Avoidance
VII. Intimacy conflict Fear of intimacy, closeness, mistrust, fear of war, worry over children, purposeful distancing	C4, 5, 6 Avoidance

\* Adapted from Wilson and Krauss (1985).



may believe that he has no right to live and attempts, directly or indirectly, to kill himself in the hope of absolving the guilt and rejoining dead buddies. Furthermore, when the depression is so severe that it impairs adaptive behavior, the individual often develops the belief that he cannot control his fate. This external locus of control (Rotter, 1966) may lead to feelings of extreme vulnerability, which, in turn, may be reacted to by increased psychic numbing and avoidance responses.

### *Anger, Rage*

It has been widely observed that many Vietnam veterans harbor an intense anger. Veterans attribute this to two sources: (1) the frustration of fighting a war that was not lost but was turned over to an inferior army (ARVN), which was subsequently defeated by North Vietnamese forces, and (2) the absence of understanding or appreciation by the government and the country for fighting in Southeast Asia.

In the first instance many Vietnam veterans feel that they were used by the government in Vietnam: they were mere pawns in the politicians' economic games. A total of 58,000 soldiers died and over 300,000 were wounded for reasons that are still unclear. Beyond that is the fact that for many men, especially those with heavy combat exposure, the war disrupted the sequence of early adult development (Wilson, 1980a). As the research studies have shown, these men achieved less educationally and occupationally than their cohorts who did not serve in the military (Egendorf et al., 1981). The same studies indicate that veterans have significantly high rates of divorce, arrests, and alcoholism which are not predictable from premorbid, racial, or demographical factors. In short, the war significantly disrupted their lives and made reentry into the mainstream of society extremely difficult. Moreover, the absence of ritual welcome, celebration, and sanctioning of their sacrifices further deepened the expectable scars that men acquire from battle. Thus, it is not surprising that many men became embittered, angry, and withdrawn. Perhaps for this reason many men harbor fantasies of retaliation (Wilson, 1980a) in which they wish to "pay back" those they perceive as responsible for their current malaise and status in society. Indeed, over the past 10 years I have been surprised at the strong emotionally welled-up response exhibited when one says to these individuals, "Thank you for serving." What is especially sad about this phenomenon is that most Vietnam veterans have never been thanked for their contributions in a difficult and controversial war. Finally, it should also be noted here that nothing angers them more quickly than the allegation that



they lost the war. On the contrary, Vietnam veterans are quietly proud of the way they fought in Vietnam; they were good soldiers who did a competent job in combat. What is distressing to them is that the decision to pull out of Southeast Asia not only intensified the feeling that it was all for nothing, but erroneously focused the responsibility on them as soldiers rather than on the government officials who made the decision.

### *Intrusive Imagery/Affective Flooding*

Intrusive imagery and affective flooding describe two distinct forms of reliving some element of the traumatic event. Intrusive imagery refers to the sudden onset of images or memories of stressful experiences. As Horowitz (1979) has defined this process, intrusive imagery is unbidden and is usually associated with a heightened sense of vulnerability, anxiety, and feeling out of control. The images may be quick and fleeting or intense and prolonged, dominating consciousness and behavior. In the extreme case of dissociated states of consciousness there are actual or symbolic reenactments of an earlier episode. Images may occur at night (in dreams) or during the day when awake. For Vietnam veterans, intrusive imagery can span the entire range of war stress from seeing atrocities to dead children.

*Affective flooding* is the companion to intrusive imagery. Affective flooding means that the victim is overcome with intense, negative emotion: anxiety, anger, rage, sadness, depression, or remorse. Affective flooding can occur *without* intrusive imagery or memories of past events. In such cases, the individual's defense mechanisms block the recognition of the thoughts associated with the intense emotions. These ego defenses include repression, denial, psychic numbing, and psychogenic amnesia. When there are repeated episodes of affective flooding without associated memories or intrusive imagery, it may be necessary for the therapist to help the patient connect the unconscious thoughts with their affect to facilitate the stress recovery process of working through the unassimilated components of the experience. When the resistance to this process is strong, it is likely that the patient fears he or she might decompensate and become totally out of control (i.e., enraged, helpless, or filled with depressive guilt). In severe cases of PTSD in Vietnam veterans, careful evaluation must be made to determine whether or not the patient requires a "safe" place to "let go" of the trauma. A safe place may be an inpatient PTSD ward in a VA hospital or an equivalent supportive therapeutic milieu where the individual is able to permit



feelings of vulnerability to emerge and confront the painful but unresolved conflicts. However, many licensed, accredited mental hospital wards are not safe and supportive. In order to avoid further harm of Vietnam veterans with PTSD, it is necessary that experienced practitioners carry out post-traumatic therapy.

### *Emotional Constriction/Avoidance*

In DSM-III-R (APA, 1987) the third ("C") set of diagnostic criteria focus on

persistent avoidance of stimuli associated with the trauma or numbing of responsiveness (not present before the trauma), as indicated by at least three of the following: (1) efforts to avoid thoughts or feelings associated with the trauma; (2) efforts to avoid activities or situations that arouse recollections of the trauma; (3) inability to recall an important aspect of the trauma (psychogenic amnesia); (4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills; (5) feeling of detachment or estrangement from others; (6) restricted range of affect, e.g., unable to have loving feelings; (7) sense of a foreshortened future, e.g., child does not expect to have a career, marriage, or children, or a long life. (p. 250)

These diagnostic criteria are quite useful in identifying both the forms of avoidance in PTSD and their internal mechanisms. Thus, avoidance can be construed to fall along a continuum which may range from *complete* avoidance (i.e., self-thoughts and feelings, situations, interpersonal attachment, and leisure activities) to *selective* avoidance of only some types of situations, for example, rap groups with other veterans or movies about the war which would trigger excessive arousal and psychic distress. However, other situations might not be avoided, such as intimate contact with a supportive spouse or a significant other. Furthermore, when there are moderate to strong symptoms of emotional constriction, the individual is also likely to manifest other characteristics, such as psychic numbing, desexualization (actual unresponsiveness or decreased libido and loss of interest in sex), social phobias (crowds, movie theaters, etc.), problems of concentration, social isolation and withdrawal, loss of goal directedness, and self-medication with alcohol and drugs.

The central mechanism of the avoidance mechanism of PTSD is the



ego defense of denial. Although the conceptual status of denial is by no means clear or unidimensional (Breznitz, 1983), it can facilitate either adaptive or maladaptive forms of coping (see Horowitz, 1979, and Janis, 1983, for discussions). Horowitz (1979) has delineated and operationally defined the signs and symptoms of denial, which include:

- (1) avoidance of associational connections; (2) numbness; (3) reduced level of feeling of responses to outer stimuli; (4) rigidly role-adherent or stereotyped; (5) loss of reality appropriacy of thought by switching attitudes; (6) unrealistic narrowing of attention, vagueness, or disavowal of stimuli; (7) inattention daze; (8) inflexibility or constriction of thought; (9) loss of train of thought; (10) loss of reality appropriacy of thought by sliding meanings; (11) memory failure; (12) disavowal; (13) warding off trains of reality-oriented thought by use of fantasy. (p. 239)

Thus, these symptoms of denial indicate the internal, cognitive processes that govern the individual's adaptive behavior and responses to trauma-related material. When the various denial mechanisms are strong, they permeate all levels of psychic functioning and interpersonal behavior by diminishing responsiveness to the self and the distortion, in one form or another, of the external world. Viewed in this perspective *the mechanisms of denial are safety-oriented modes of information processing* (see Aronoff & Wilson, 1985). By constricting attention, perception, memory, thinking, and interpersonal transactions the person creates a rigid and predictable mode of information processing that minimizes anxiety and the need to meet the requirements of unfamiliar or new situations. *Thus, the denial mechanism is a control operation whose function is to enhance a sense of security and to stave off the tacit fear of being overwhelmed and traumatized again.* However, the vulnerability of this defensive operation is that when control fails, the individual is likely to experience intrusive imagery, affective flooding, confusion, feelings of helplessness, identity confusion, fear of annihilation, or panic, which, in turn, may lead to adaptive behavior which includes hypervigilance, aggressiveness, paranoid suspicion, isolation, or sensation-seeking tendencies.

### *Hyperarousal/Sensation Seeking*

Among the many qualities that distinguish Vietnam veterans from other survivors of trauma is their degree of personal intensity. Although



this intensity has its origin in cultural and individual factors, the major cause stems directly from the realities and demands of fighting a guerilla war in the dense jungles, rice paddies, and rivers of Southeast Asia. In that environment, replete with oppressive heat, the unpredictable location of omnipresent booby traps, and a tenacious and resourceful enemy, hyperalertness was the psychic condition required for survival. Indeed, in U.S. Army training materials the soldier was told that to be alert meant to be alive. Clearly, this is a truism in most wars, but it was even more significant in a search-and-destroy guerilla war which was full of ambiguities and uncertainties regarding the enemy's location and methods of attack. Thus, the psychological consequence of this situation is that perceptual, sensory, motor, proprioceptive, and other nervous system functions are heightened to the maximal degree in order to survive. These neurophysiological systems frequently exceeded the optimal level of arousal. Although there are varying thoughts about the long-term consequences of heightened states of arousal (see van der Kolk, 1984), it is possible that at a minimum there are: (1) conditioned emotional responses that Kolb, Burris, and Griffiths (1984) characterize as "a persisting potential for abnormal physiological arousal to any perceived bodily threat and the related emotional state (a physioneurosis), and (2) secondary attempts at adaptation to both the disturbed perceptions of the self as well as existing and pre-existing social representations" (p. 100). Thus, this theoretical view, based on learning theory and cortical arousal mechanisms, suggests that hyperarousal does not extinguish easily because of the phenomena of stimulus generalization. This is consistent with my view that hyperarousal among Vietnam veterans is a prominent symptom because this cortical-physiological state was reinforced in Vietnam by survival. Stated simply, hyperarousal paid off—it kept the soldier alive and adapted to a threatening environment. A similar conceptualization has been put forth by de la Pena (1984), who states that

any environmental circumstance that provides an accelerated rate of information flow for the brain (e.g., learning new material in school or having to identify quickly informative elements during combat experience) thus has the effect of building up increasingly sophisticated and comprehensive cognitive programs for information processing and/or information reduction. That is, out of necessity for survival, the brain experiencing a surfeit of information flow must construct increasingly efficient programs for information processing in order to maintain information flow rates within tolerable limits. Construction of new cognitive (cortical)



models enhances the selective destruction of irrelevant, redundant information considered to be necessary for the task at hand . . . the business survival of a combat environment. (pp. 111-112)

Taking the logic of this position to its fullest implication, is it possible that heightened cortical arousal and the construction of new modes of information processing may reprogram the way the nervous system responds to environmental stimuli. Thus, it may be the case that emotional constriction and avoidance represent attempts to reduce hyperarousal states by safety-oriented modes of information processing, that is, decreased levels of information search, decreased processing persistence, flexibility, and conceptual differentiation (see Aronoff & Wilson, 1985). The outcome of this cognitive style may then be a lowered level of aspiration and the inability to initiate efficacious adaptive behavior.

#### *Sensation Seeking as the Maintenance of Hyperaroused Cognitive-Physiological States*

One form of reliving the traumatic event among victims is the sensation-seeking syndrome (Zuckerman, 1979; Wilson & Zigelbaum, 1983). In the sensation syndrome the individual maintains a hyperarousal state that recreates or parallels the level of cortical-physiological arousal experienced in the trauma. Typically, such persons seek out experiences that are adventuresome, challenging, risky, dangerous, and exciting because they either maintain or induce the hyperarousal state of being. Viewed from psychodynamic, physiological, and cognitive-informational processing points of view, there are several central features and functions of this syndrome of post-traumatic adaptation. First, it is a form of repetition compulsion because the hyperarousal state is similar to that experienced in the war zone; that is, it "repeats" the psychological state but in a different environment. Second, the hyperarousal state experienced in sensation seeking requires a cognitive program of an accelerated rate of information processing. Thus, the experiences of sensation seeking may activate those cognitive programs and emotional states that led to survival, effective coping, and organismic competency. In this regard there is ego mastery over the challenge, which enhances the sense of the self as alive, competent, and efficacious. Thus, it may provide gratification of esteem needs that might not be obtained from more conventional pursuits. Third, it is highly likely that the activity level and cortical arousal induced by sensation-seeking behaviors are



associated with increased endorphin production, which, in turn, serves as a natural antidepressant. Given that this is so, the sensation-seeking syndrome contains a built-in neurological reinforcer which not only works as an antidepressant, but rewards the motivational cycle itself. For this reason, these individuals are referred to as "action addicts" because of their subjective expressions that they "need" the action in order to feel congruent in their personality. In this regard the syndrome reverses normal personality functioning in that the hyperarousal state is the preferred baseline of behavior. The absence of hyperarousal is often experienced as boring, stressful, painful, or as a state of stasis (Lifton, 1976) that may be accompanied by images and fears of death and nonbeing. Finally, it is clinically demonstrable that when the syndrome is stopped for any reason, the victim typically gets depressed and has more episodes of intrusive imagery and nightmares and an intensification of anxiety and sleep disturbances. It is likely that in severe cases of PTSD this form of adaptation (sensation seeking) is primarily defensive in nature because the behaviors not only recreate the survivor mode of functioning, but block the cognitive processing of those parts of the trauma that have not been assimilated into the self-structure.

#### *Stigmatization/Alienation*

In the beginning of the chapter I noted that it is possible to think of Vietnam veterans as victims because of rejection, exploitation, and the absence of rituals to transform the warrior identity into a more productive set of roles in society. Instead, it was almost as if society placed the burden of responsibility of the war onto the shoulders of the veteran. Rather than recognizing their sacrifices and patriotism, the common media image was that of the tainted, drug-addicted, emotionally volatile "baby killer" (see Leventman & Camacho, 1980). Clearly, this stereotype is false and simplistic, but it does illustrate the fact that the controversies over the legitimacy of the war extended full circle; those men and women who were called to serve their country were now being chastised for doing so. Beyond that were the very real difficulties of beginning a career or attending school on inadequate government benefits. For these reasons, many Vietnam veterans became alienated, angry, and mistrustful of authority because their faith and trust in the benevolence of leaders had been violated too many times during the war and afterward. Moreover, their personal struggle to sort out the



meaning of the war experiences and its impact on individual identity and ideology led to a changed world view. Now there was a heightened sensitivity to justice, fairness, equity, deceit, phoniness, lies, the use of power, and principles of morality.

Many Vietnam veterans realized after the war that they had changed and no longer fit into the conventional society they left behind to go to war. In just one year their world had been so transformed that upon return many men and women felt like strangers in a strange land. Actually, the society of the 1960s and 1970s was not all that strange, despite rapid social change and upheaval; it was the veteran who could not subscribe to many aspects of a materially oriented culture. The realities of war, life-and-death situations, the intense bonding with buddies, the exercise of important decision making, and the day-to-day struggle to survive caused them to ask deep philosophical and psychological questions that their friends and relatives back home would have difficulty understanding. This struggle to formulate the meaning of their war experiences, as well as the fear of stigmatization if others were to learn about the grotesque realities of guerilla warfare, caused many Vietnam veterans to become *psychologically isolated*. Most veterans simply did not talk about Vietnam because they feared (as do most individuals who have been traumatized) that no one would understand what Vietnam was all about. For this and other reasons mentioned above, the typical individual was self-conscious about his status as a veteran. On the one hand, there was a secret pride in knowing that they did their best as soldiers who cared for their buddies in a difficult war; on the other hand, there was the lonely and often painful struggle to know whether or not it was all for nothing.

### *Intimacy Conflict*

Intimacy conflict occurs when the establishment or maintenance of trusting interpersonal relations is impaired by the symptoms of PTSD. For the Vietnam veteran there are frequently anxieties associated with getting close to others, even spouses and children. Wilson (1980a) has written that *purposeful distantiation* was a coping pattern developed in Vietnam in response to the injury or death of a member of a military unit. In purposeful distantiation the individual controls the degree of emotional attachment by partially numbing feelings and by not permitting personal disclosure that would lead to the formation of friendship or deeper levels of caring for others. In this way, the emotional numbing,



especially when combined with hyperarousal states, ensured during combat that the function of behavior was survival. Wilson (1980a) has further indicated that:

while the confrontation with death and the realities of war led to purposeful distantiation, it also created the need to know oneself more fully and to be genuinely close to others. Yet, this learned modality of interpersonal involvement that maintained a psychologically safe distance did not extinguish upon coming home from the war. Rather, the social conditions of the time contributed to its prolonged use even though purposeful distantiation was not conducive to healthy psychosocial growth and development. Where this strategy of interpersonal involvement persisted the individual was likely to have difficulties in establishing intimate relationships and a sense of belonging and rootedness in a community meaningful to him or her. In its extreme form, the consequences of purposeful distantiation is loneliness and alienation. (p. 159)

One of the paradoxes of PTSD among Vietnam veterans centers around the ego-defensive quality of purposeful distantiation. In order to have truly intimate interpersonal relations, the individual has to learn to trust, to disclose personal concerns, and to render oneself potentially vulnerable to hurt, rejection, and failure. However, the powerful presence of hyperarousal states leads to defenses against feeling vulnerable. One is threatened by "openness" and having no psychic armor against a state of "unpreparedness." *The survivor mode of functioning (i.e., hyperarousal leading to emotional constriction, depression, affective flooding, or sensation seeking) always works against feelings of vulnerability, perceived threats, and being in a position of unguardedness. Thus, the paradox of PTSD is that in order to recover from the stress disorder the individual must "let go" of survivor mode functioning in order to come to terms with the unassimilated elements of the trauma. However, it is an extremely difficult process to accomplish because survivor mode functioning is what led to survival in the first instance. Intrapsychically, then, to give up survivor mode functioning is often subjectively experienced as death anxiety because of the unconscious belief that without it the individual self will die or be injured. Of course, such anxieties can be traced back to the episodes of combat and the loss of buddies. In the present, however, many stimuli and situations can have the functional equivalence of war stressors and activate states of hyperarousal and the cognitive programs that govern adaptive behavior. In the context of love relationships, the illness of a child, the frustration of a partner*



and the relationship, the loss of work, and many other stressors can aggravate the PTSD and increase the likelihood of purposeful distancing out of the fear of loss, rejection, repudiation, or humiliation. The result, more often than not, is conflict over intimacy.

## DIFFERENTIAL DIAGNOSIS: ISSUES AND NEW DIRECTIONS

Prior to the development of DSM-III, many cases of PTSD either went undiagnosed or were misdiagnosed, primarily as depression, paranoid schizophrenia, or character and behavior disorders. This situation was unfortunate for several reasons. First, it shows that in many cases an inadequate history of the patient was taken which failed to explore the trauma in great enough detail to link experiences in the stressful life event to current symptoms. Second, it reflects a tendency to overly rely on diagnostic manuals to compartmentalize complex human processes. In part, this phenomenon is a direct product of implicit theoretical assumptions about mental disorders. However, in the case of war veterans it has long been noted that war stress can produce massive and lasting changes in personality and adaptive behavior (e.g., Kardiner, 1941; Archibald & Tuddenham, 1965).

Perhaps no other area of research on Vietnam veterans has generated as much controversy as the issue of the differential diagnosis. As noted by others (Boulanger, 1985; Green, Wilson, & Lindy, 1985; Figley, 1978; Wilson, 1980a; Wilson & Krauss, 1985), the discussion of the phenomena of PTSD quickly draws forth ideological biases and implicit theoretical assumptions about the nature of stress and the psychological processes by which individuals perceive, evaluate, adapt to, and assimilate stressful life events (see also Lazarus & Folkman, 1984, for a discussion of these issues). More recently, Blank (1985) has written convincingly about irrational reactions to PTSD and Vietnam veterans. As with many other areas of scientific inquiry, the debate over the possible clinical and life-course effects of combat exposure will ultimately generate more adequate sets of data, new theoretical paradigms of human personality functioning (see Lifton, 1976, for a lucid analysis of paradigm shift), new analytical techniques, and a variety of advancements in clinical practice, assessment, and diagnosis. At present, however, our empirical knowledge of PTSD is comparatively smaller than that which exists for other mental disorders. Nevertheless, several important findings have emerged from the research programs.



First, Laufer, Brett, and Gallops (1984) have questioned the conceptual adequacy of the DSM-III diagnostic scheme and proposed a dual-stress model that identifies a denial form and a reexperiencing form of PTSD. Comparing men who had either witnessed or participated in an atrocity, they found that the dual-stress model had a somewhat greater predictive power than did the DSM-III model in terms of identifying the percentage of men who manifest PTSD symptoms. Furthermore, a follow-up study revealed that subjective reactions to combat exposure, seeing Vietnamese and Americans killed, and exposure to atrocities were correlated with different dimensions of the dual-stress model. These findings are heuristically valuable because they point to the complexities in predicting and differentiating PTSD among individuals exposed to qualitatively different stressors in the Vietnam War. Similar results have been found by Wilson, Smith, and Johnson (1985); Wilson and Krauss (1985); Green, Lindy, and Grace (1984); Gleser, Green, and Winget (1981); and Card (1983).

To complicate these issues even further, the preliminary data analyses of Green, Lindy, and Grace (1984) found that only 13% of a treatment-seeking population of Vietnam veterans manifest a single diagnosis of PTSD. Thus, the other veterans in the sample tended to have multiple diagnoses or diagnoses other than PTSD. Moreover, the preliminary and exploratory results on the frequency of diagnosis for personality disorder revealed high levels of schizotypal, paranoid, and borderline personality disorders. These results are subject to multiple interpretations because of the limitations of the sample, the unstandardized questionnaire to assess the personality disorder, and other methodological problems. Despite these limitations, the results suggest that PTSD may be a multidimensional process that can alter, transform, or exacerbate core personality processes after the war and throughout the entire life-cycle.

#### THE RELATION OF PTSD TO PERSONALITY DISORDERS: THE LINK BETWEEN HYPERAROUSAL STATES AND PERSONALITY PROPENSITIES

While the debate over the nature, diagnosis, categorization, and etiology of personality disorders will occupy much future research in psychiatry and psychology, it is important to attempt to specify the relationship of PTSD to personality disorders. There are several reasons that this is especially germane to understanding Vietnam veterans. First,



some symptom clusters and behavioral responses overlap for PTSD and personality disorders. Therefore, to avoid misdiagnosis one has to recognize that it is very easy to misinterpret certain response styles that are PTSD-related coping mechanisms learned in survival situations (e.g., hypervigilance, isolation, guilt, aggressive reactions, mistrust, expectation of harm, and so forth). Although such behaviors may *not* be optimally adaptive in today's society, they were often reinforced time and time again in the jungles of Vietnam. Thus, in order to understand the relationship of PTSD to personality disorders requires knowledge of the link between the chronic, hyperarousal state inherent in PTSD and premorbid personality propensities. Consistent with the approach of Millon and Everly (1985), personality propensity refers to the enduring, stable structure of personality that was formed in epigenetic development prior to entry into military service. Following modern personality theory and research (Aronoff & Wilson, 1985), personality propensities are partially biological in nature and the result of life course development. More important, persons vary reliably and predictably on the different, but limited, dimensions of personality structure. Thus, when we think about the fact that in the Vietnam War the combatant was about 19 years old and in the stage of transition into early adulthood, it serves to clarify how a one-year tour of duty, replete with multiple stressor experiences and traumas, could impact on personality propensities and ego identity. For example, if the individual was extroverted, active, energetic, dominant, and self-confident prior to the war, he may then show similar traits when coping with PTSD, if it occurs. Therefore, we expect to see the core symptoms of PTSD and active, forceful, and aggressive modes of coping with the hyperarousal state of the stress syndrome. Stated in another way, traumatic stressors may leave their imprint on the psyche of the survivor, but *how* the person processes the trauma, both during it and afterward, is largely determined by personality processes (i.e., traits, defenses, coping styles, temperament, intelligence) that existed before the stressful life events.

The implication of this position of the interaction between personality propensities and the response to trauma is clear in terms of making DSM-III-R diagnoses. First, it suggests that there is likely to be a great deal of coherency to the way in which a survivor copes with trauma. Second, this coherency will be evident in personality functioning in a way that is discernible from: (1) knowledge of the pre-trauma personality structure; (2) the nature and role of the person in the trauma; (3) the situational appraisal of the trauma and initial coping response; and (4) post-trauma attempts at assimilation of the experience. Viewed in



this way, the underlying coherency of personality and its linkage to PTSD enables the clinician to obtain a more holistic perspective of the veteran, one that is not obvious from a more traditional perspective of personality disorders. Furthermore, in my clinical and forensic work with Vietnam veterans I have found it highly common for them to exhibit several of the symptoms of schizotypal, paranoid, borderline, and narcissistic personality disorders. But does this necessarily mean that they had those particular attributes prior to going to Vietnam? In most cases I have not found any hard evidence of a preexisting personality disorder. Yet, many of these men meet the DSM-III criteria for the personality disorder listed above. One way to understand this apparent contradiction is to note that many of the explicit diagnostic criteria for the personality disorders share a common variance with the diagnostic criteria and symptoms of PTSD. For example, in DSM-III schizotypal personality disorder requires that four of eight symptoms be present and includes such criteria as social isolation, depersonalization, constricted affect, and social anxiety, all of which characterize PTSD in Vietnam veterans (Wilson & Krauss, 1985). Similarly, the diagnostic criteria for paranoid personality disorder require a total of seven symptoms out of a possible 16, which are grouped into three categories: (1) mistrust of people, (2) hypersensitivity, and (3) restricted affect. Again, these categories are conceptually congruent with PTSD. More precisely, the categories contain such items as hypervigilance, expectation of harm, questioning the loyalty of others, readiness to counterattack when any threat is perceived, inability to relax, appearance of being cold and unemotional, and the absence of passive, soft, tender, and sentimental feelings. As a set these symptoms overlap with those of PTSD and its associated features (see DSM-III-R, p. 249).

When analyzing the criteria for the borderline personality disorder, the description in DSM-III-R states that

a marked and persistent identity disturbance is almost invariably present. This is often pervasive, and is manifested by uncertainty about several life issues, such as self-image, sexual orientation, long-term goals or career choice, types of friends or lovers to have, or which values to adopt. The person often experiences this instability of self-image as chronic feelings of emptiness or boredom. (p. 346)

To receive a diagnosis, a person must have five of eight possible symptoms, which include impulsivity, unstable interpersonal relation-



ships, intense anger or control of anger, affective instability, and identity disturbance. These symptoms have been found in other studies as a central manifestation of PTSD in Vietnam veterans (Figley, 1978; Wilson, 1980a; Kadushin, Boulanger, & Martin, 1982; Wilson & Krauss, 1985; Wilson, Smith, & Johnson, 1985; Arnold, 1985). Furthermore, Millon and Everly (1985) have argued that personality disorders can be classified by their biologically based instrumental behavior patterns (proactive versus reactive) and the locus of reinforcement the person uses to gratify basic needs (e.g., independent versus dependent). This matrix approach then permits a detailed description of personality in terms of a person's interpersonal conduct, cognitive style, affective expression, and self-perception.

Thus, as applied to the understanding of the relationship of PTSD to personality disorders, it can be seen that a traumatic event such as combat exposure can impact on normal personality patterns and transform them in pathological directions which might be expressed as schizotypal, paranoid, borderline, antisocial, and so forth, depending on the nature of the pre-trauma personality structure and the stage of ego development (Wilson, Smith, & Johnson, 1985; Eth & Pynoos, 1985). Furthermore, the logic of this position does not conflict with the traditional psychiatric view that most personality disorders are long-term maladaptive personality traits that originate in early social learning and constitutional factors. Rather, it augments and expands this theory by proposing that traumatic events can transform normal personality patterns in a variety of ways, including: (1) positive, adaptive, character strengthening; (2) negative, maladaptive character pathology; (3) intensification of a specific stage of ego development; (4) the development of PTSD without a personality disorder in an individual with no history of character pathology; (5) the development of PTSD and character pathology or other mental disorders. Clearly, future research, such as that now being conducted by the Research Triangle Institute on Vietnam Veterans, will address these issues and extend our knowledge of how stressful life events can affect changes in personality functioning, which may be transient, acute, or chronic in nature (see also Lazarus, DeLongis, Folkman, & Green, 1985; and Dohrenwend & Shrout, 1985, for a discussion of these issues in stress and adaptation).

In related research, Gunderson (1983) has reviewed the DSM-III diagnoses of personality disorders and concluded:

. . . many of the personality disorders can be considered to exist on continua or spectra that have diagnoses in either the psychotic



or neurotic ranges. We have noted that both DSM-II and DSM-III \* have been inconsistent with respect to how to manage this. Hence, cyclothymic personality is reclassified as a variant of the affective disorders as if the latter were the parent category. In contrast, paranoid and schizotypal personality have been retained in Axis II, with the corresponding psychotic conditions considered symptomatic exacerbation, not over-riding conditions vis-à-vis personality diagnoses . . . at present, I would include only those with both clinical tradition and empirical support, namely, histrionic, borderline, schizoid, anti-social and compulsive categories. (pp. 33-34)

Thus, based on the findings of Green, Lindy, and Grace (1984), it can be seen that differentiating the line between PTSD and the schizotypal, borderline, and paranoid personality disorders among Vietnam veterans is often difficult because the core symptoms overlap and frequently meet the diagnostic criteria of each disorder. Until a more adequate classification schema can be derived from theory, clinical practice, and empirical findings, the issue of proper differential diagnosis might not be resolved. *However, where there is no record of premorbid character disorder or such tendencies in a person who has been victimized or traumatized, the most cogent position is to suggest that the stressful event can alter the personality processes and coping patterns of the individual in several alternative forms.*

Consistent with the theory presented by Millon and Everly (1985), the traumatic event might intensify active or passive tendencies in personality. When there is an intensification or disinhibition of adaptive controls, the biologically proactive and initiating individual could manifest PTSD and antisocial, paranoid, or histrionic tendencies. When the person is biologically passive and reactive, he could exhibit PTSD and narcissistic, borderline, dependent, schizoid, and avoidant character traits. Viewed in this manner, it becomes possible to understand the various expressions of PTSD as falling along a continuum of approach or avoidance gradients of coping with the hyperaroused, neurophysiologically based cortical arousal patterns. If the individual's personality propensity is proactive and initiating, he will be more likely to show sensation-seeking, paranoid, antisocial, histrionic, and acting-out (including dissociated states) forms of coping with hyperarousal of trauma-related imagery and affect. On the other hand, if the personality pro-

\* Editor's Note. This is also true for DSM-III-R.



pensity is reactive and passive, he will be more likely to manifest depression, emotional constriction, avoidance, borderline, and schizotypal qualities in coping with hyperarousal. Thus, true differential diagnosis of PTSD must move beyond nosological categories to a more integrated and differentiated approach that considers personality processes, psychosocial stages of life-span development, the nature of hyperarousal states, and the specific content of the traumatic material that is unresolved.

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# 12

## *Treating the Vietnam Veteran*

JOHN P. WILSON

POST-TRAUMATIC TREATMENT:  
APPROACHES, TECHNIQUES, AND PRINCIPLES  
OF PSYCHOTHERAPY

### *Traumatic Neurosis*

When an individual has gone through a traumatic event, his normal psychological equilibrium is upset. The stressful life event generally produces feelings that include shock, numbing, anger, rage, denial, disavowal, tension, and grief. Indeed, Freud (1963) defined traumatic neurosis as a response to excessive excitation in a short period of time that penetrated the protective shield of ego defenses. He wrote

The traumatic neuroses are not fundamentally the same as those which occur spontaneously, which we investigate analytically and are accustomed to treat; neither have we been successful so far in correlating them with our view on other subjects; later on I hope to show where this limitation lies. Yet there is complete agreement between them on one point which may be emphasized. The traumatic neuroses demonstrate very clearly that a fixation to the moment of the traumatic occurrence lies at their root. These patients regularly produce the traumatic situation in dreams; in cases showing attacks of an hysterical type in which analysis is possible, it appears that the attack constitutes a complete reproduction of this situation. It is as though these persons had not



yet dealt adequately with the situation, as if the task were still actually before them unaccomplished. . . . An experience which we call traumatic is one which within a very short space of time subjects the mind to such a high degree of stimulation that assimilation or elaboration of it can no longer be effected by normal means, so that lasting disturbance must result in the distribution of the energy in the mind. (p. 243)

In Freud's view, based on the economic model of neurosis, the traumatized ego contracts because attention is focused on thoughts and feelings connected to the trauma and therefore has less psychic energy available for reality testing (i.e., secondary process functioning). Thus, the persistence of concerns with the trauma, accompanied by anxiety, depression, sleep disturbance, and nightmares, constitutes the core process of a traumatic neurosis. Treatment of this condition was then approached from the perspective of three principles: abreaction, catharsis, and working through the unassimilated material. However, as Horowitz (1986) notes, clinicians during World War II placed greater emphasis on abreaction and catharsis, aided by hypnosis and narcohypnosis, than they did on the working-through process whose focus was the restoration of normal, adaptive controls within the patient. A further theoretical assumption of this model of traumatic neurosis was that with adequate rest and treatment, the traumatized patient would return to normal functioning within a reasonable amount of time. If neurotic symptoms persisted, it was assumed that the trauma had unleashed repressed conflicts within the character structure of the person. Although such logic is internally consistent with an instinctual model of behavior, it ignores the nature of the trauma as a determinant of the duration of the recovery.

#### *Horowitz's Modern Phase-Oriented Treatment*

In recent years newer conceptualizations of PTSD and its treatment have developed out of the historical events and research studies of the last 50 years (e.g., Hiroshima, World War II, the Nazi Holocaust, Korean War, Vietnam War, Buffalo Creek Dam disaster, etc.). Among the more systematic programs to study PTSD and psychotherapy outcomes has been that of Mardi Horowitz and his associates at the Center for the Study of Neuroses, in California. In describing the pattern of treatment, Horowitz (1982) writes:

After a serious life event, persons usually reconsider the meanings



and plans for response to that event in a manner that is systematic, step by step, and dosed. When emotional responses become excessive, or threaten flooding, the person initiates control operations. The recollection of the unfinished processing of sets of meanings will tend to counteract these controls. When the person cannot handle both the repetition compulsion and the defensive counters, he seeks help. The therapist establishes a working alliance through which he assists the patient in working through the natural responses to the event to the overall situation. In addition, efforts may be directed at modification of preexisting conflicts, developmental difficulties, and defensive styles that made the person unusually vulnerable to traumatization by this particular experience. Therapy depends, in part, on establishing a safe relationship. Once this is done, work within the therapy alters the status of the patient's controls. With a safe relationship and gradual modification of controls, the patient can then proceed to reappraise the serious life event, and the meanings associated with it, and make the necessary revisions of his inner models of himself and the world. As this reappraisal and revision take place, the person is in a position to make new decisions and to engage in adaptive actions. He can practice the altered models until they gradually become automatic. Overlapping with these processes is the necessity of working through reactions to the approaching loss of the therapist and the therapy. (pp. 728-729)

In his writing about stress syndromes Horowitz (1976, 1979, 1986) has combined the principles of psychodynamic theory with an information-processing model of stressful life events. This integrated model proposes that there is a natural sequence of stages to the stress recovery process which begins with outcry and moves on through the stages of avoidance, intrusive imagery, and affective flooding to a period of working through wherein adaptive controls diminish the sense of being traumatized and cognitive reappraisal enables the person to make congruent the self-schemata and the memories of the trauma. As a general summary of the task of psychotherapy, Horowitz (1986) writes:

Modifying excessive controls, altering pathological defensive stances, and supporting weak regulatory capacities all are part of the treatment of stress response syndrome. These coping and defensive conditions are set in motion by the impact of the stressor events; yet they are also a product of a long-standing personality styles. The patient's character also includes enduring schemata of self, others, and relationships, as well as persistent life agenda encom-



passing unconscious scenarios of how the person hopes life will turn out. The treatment invariably involves work with coping and defensive strategies, as well as with the repertoire mentioned above, whether or not these levels or immediate reaction or personality are interpreted. This treatment is both specific and general. (p. 112)

Based on years of treating persons who were victims of trauma, Horowitz and his associates have evolved a set of general treatment principles for the phase-oriented stages of PTSD. (See Horowitz, Marmar, Krupnick, Wilner, Kaltreider, & Wallerstein, 1984.)

Among the major treatment principles identified as important to the treatment of PTSD are the following: (1) support, (2) modulation of work and activities, (3) facilitating sleep, (4) awareness of cognitive impairment and risk of injury as a result, (5) need for empathic listening, (6) educating patient about the stages of stress recovery, (7) low pressure during denial phase, (8) structuring time limited therapy if trauma is not too extreme and/or complicated by personality disorders, and (9) time-unlimited therapy for certain chronic stress syndromes. These principles of treatment recognize the dynamics of stress recovery and the conditions that are necessary to help the patient institute adaptive controls that attenuate symptoms and facilitate the process of assimilating the traumatic experience into the self-structure. Thus, it is critical that emotional support be present from family, friends, support groups, and the primary therapist. Moreover, since the victim is experiencing psychological disequilibrium, numbing, and information overload (Green et al., 1985), he must be apprised that he may need to modulate work and leisure activities since he will be fatigued from the trauma and be less able to fully attend to the normal demands of work, family, and social life. In this regard, steps to facilitate sleep may be necessary, such as having a trusted friend stay in the room at night to reassure the patient that he will be there to offer support. Furthermore, since the victim often oscillates attention between trauma imagery and the demands of work, he may have problems of concentration and that puts him at risk of injury or poor job performance.

In other ways it is important that empathic, nonjudgmental listening occur in the therapeutic setting and that the patient learn about the stages of the stress recovery process. Horowitz (1986) notes that during the denial phase

patients may be urged to take a one-dose-at-a-time approach,



contemplating putting off the next considerations for a short period of time. This kind of reassurance indicates to the patients that they do not have to confront everything at once.

This principle recognizes implicitly the natural tendency of victims to avoid dealing with the painful aspects of what happened and the need to self-pace the rate of processing traumatic material. However, when the stressful event is not too severe or likely to lead to chronic stress, a time-limited therapy (12 to 15 weeks) may set parameters on the therapeutic process, facilitate the therapeutic alliance, and place reasonable pressure on the patient to deal with what happened. However, in chronic complex cases of PTSD, the victim may require time-unlimited therapy, when possible, to work through the impact of the trauma on personality processes. This may be especially necessary when PTSD coexists with personality disorders, which we know from the research (Green, Lindy & Grace, 1984) are common among Vietnam veterans who are likely to manifest schizotypal, borderline, and paranoid characteristics.

#### *PTSD and Personality Disorders: Complex Treatment Issues*

The victim's pre-trauma personality propensities (e.g., cognitive style, coping patterns, predominant traits, etc.) moderate the way in which the trauma is assimilated into the self-structure. Thus, psychotherapy has to take into account the specific ways in which these personality mechanisms affect the victim's ability to deal with the trauma at each stage of the recovery process. However, it is difficult to know where the personality disorder ends and the PTSD begins. Often the two processes become inextricably linked. When this is the case, the therapist must decide whether the patient is a traumatized individual who will benefit from post-traumatic therapy or is one who is more characterologically impaired and prone to repetitive patterns of maladaptive behaviors that are only partially associated with the stress recovery process, or both. Thus, time-unlimited therapy may help such individuals gain insight into the way that their character structure evolved and affected their style of coping with the trauma. This process is likely to be long and arduous because the narcissistic wounds to the self-structure are so great that: (1) the character pathology can be viewed as a defense against these injuries (Kernberg, 1984) and (2) the traumatic event typically weakens controls, which renders the person vulnerable to further narcissistic scarring, i.e., a fragile and disorganized self-structure.



In response to the increased narcissistic injury, the victim may adopt a survivor modality of coping or intensify defensive controls associated with the personality disorder. In this regard, it is proper to speak of the personality disorder and PTSD as layered psychological processes that create a feedback loop into each other. In this analogy, then, the focus of therapy is to understand the mechanisms of the loop in order to determine how each phenomenon controls and regulates the other.

#### *Other Approaches to the Treatment of PTSD Among Vietnam Veterans*

In recent years, particularly as the research and clinical basis of understanding and treating PTSD has grown, a variety of therapeutic approaches have been developed and applied to healing and alleviating war stress. Generally, these approaches overlap to some extent in the domain of techniques used to reduce and treat the stress symptoms. For example, Smith (1985) and Scurfield (1985) have stated treatment principles that include: trust, stress management, transformation and reliving the war stress, education about the stress recovery process, management of anger, and the need for individual, group, and family therapy as part of the overall treatment plan. In a more behaviorally oriented approach, based on the principles of learning theory, systematic desensitization, and other applied behavioral techniques, Keane, Fairbank, Caddell, Zimering, and Bender (1985) have discussed their comprehensive treatment plan. This program applies implosive therapy, relaxation training, positive imagery training, deconditioning procedures, stress management techniques, and cognitive restructuring of the symptoms of PTSD. One of the strengths of this program is the careful assessment of changes in symptom clusters associated with the different treatment techniques. Although there is currently insufficient knowledge regarding the long-term effectiveness of this approach, the preliminary findings suggest that the deconditioning and desensitizing procedures can alleviate the acute symptoms of anxiety and reexperiencing of war stress.

#### *Figley's Algorithmic Approach to Treatment*

In an attempt to develop a treatment approach that is generic in nature, Figley (1985) developed an algorithmic approach which incorporates many of the features of phase-oriented treatment, systematic desensitization, and rational emotive therapy.

The algorithmic approach derives its name from a procedure for



solving a mathematical problem through a series of steps that frequently involve repetition of an operation. Figley believes that clients suffering from PTSD are experiencing, among other things, difficulties in memory management and integration. The basis of the treatment is to identify and effectively process (manage and integrate) various episodes of traumatic events that took place during the catastrophe.

Thus, a "clinical algorithm," then, repetitiously uses a clinical intervention pattern for solving or breaking through a particular psychological dilemma. Applied to PTSD the psychological dilemma is most often the trauma induction points during a frightening experience. Such traumatizing points of life are often forgotten, voluntarily or involuntarily, by the victim. The purpose of the algorithmic approach is to assist the client to remember not only the traumatizing points, but also the circumstances surrounding the points. In the process of recalling, new insights emerge which purge and neutralize the traumatic nature of the memory.

The treatment algorithm has four components: trauma assessment, traumatic induction recapitulation, trauma neutralization, and trauma resolution.

1. *Catastrophe assessment.* Pretreatment contacts will have confirmed at least one traumatic episode. For example, a war veteran may have mentioned being troubled by an incident that resulted in the death of a fellow combatant. Early in the treatment program the clinician helps the client identify as many traumatic episodes as possible and determine the order of severity. It is expected that many other episodes with greater severity will be determined in the treatment process.

2. *Traumatic induction recapitulation.* Once the target episode is identified as to time, place, and circumstances, the clinician guides the client in an exposition of the relevant experiences leading up to the particular event. Stress management techniques are employed as needed. Appropriate pacing is especially important here and in the next phase.

3. *Trauma neutralization.* After the entire episode is described in detail, including facets long forgotten by the client, the clinician guides the client in a reconceptualization of the episode. This may include reinforcing client insights, challenging illogical conclusions, using paradoxical techniques, and introducing alternative explanations and conclusions. As a result, the client reaches new and more acceptable conclusions



about the once traumatizing episode and is more equipped to face more stressful episodes.

4. *Trauma resolution.* After all the known and rediscovered traumatic episodes are identified and neutralized to the extent possible, the clinician facilitates the development of a "healing theory" of the traumatic event. In the process five "victim" questions are answered: What happened? Why did it happen? Why did I act the way I did? Why have I acted the way I have since then? And, if it happens again, what will I do to cope? The last facet of the treatment program focuses on the client's self-esteem. The goal is to apply the client's new insights in his or her self evaluation and identification of new goals and aspirations in life.

#### CULTURAL CONSIDERATIONS IN THE TREATMENT OF PTSD

Although PTSD undoubtedly has both biological (e.g., hyperarousal) and psychosocial dimensions (e.g., stigmatization and alienation), it also has a cultural perspective. Clearly, if it is the case that an individual brings to a traumatic event his or her personality style, then it is also true that cultural heritage will affect perception of the stressful event and the subsequent interpretation and processing of it. For example, Parson (1985) has written extensively and eloquently about ethnicity and traumatic stress. He has written persuasively that psychotherapy will not be fully effective if the therapist does not understand the ethnic and cultural factors that affect the patient's processing of the traumatic event. He writes:

Therapists are encouraged to study, seek supervision, re-examine their own ethnocentrism, and maintain an openness to learn from their clients. These kinds of actions, when taken by therapists, reflect humility and acknowledgment that their formal training and experience may need to be modified by incorporation of ethnically relevant information, training and experience. This awareness frees the therapist to relax his or her own ethnocultural defensiveness around racial and cultural issues. Therapist ethnocentric "blind spots" account for most of the reported underutilization of mental health services by ethnic minorities. (p. 333)



In his clinical experiences, Parson (1985) has identified at least seven principles of transethnic treatment, including: (1) awareness of acculturation strain and being viewed as inferior by society, (2) awareness of ethnic identity and belief system, (3) the development of flexible approach to treatment, (4) the awareness of therapists' ethnocentric tendencies, biases, and cultural assumptions, (5) the need to study the ethnohistorical roots of the client, (6) to receive training in multiethnic perspective, and (7) to receive special supervision from an experienced therapist with an appropriate ethnic background. Thus, by adhering to these general principles mental health professionals can circumvent some of the traps and resistances that would impede progress in treating PTSD.

*Native American Healing and Purification Rituals:  
A Spiritual Treatment for PTSD Among Vietnam Veterans*

In different cultures throughout the world religious and ritualistic practices have been developed to treat emotional illness, stress, and states of "dispiritedness." These rituals have, of course, both specific and general purposes in terms of cultural values and psychological adaptation. There are rituals surrounding death (e.g., sitting, wake) which are designed to facilitate the expression of grief and the loss of a loved one. In various rites of passage the ritual serves to change status and identity within a group, such as the confirmation of manhood. Similarly, there are rituals that prepare men for battle and return from it. Among some Native American groups, war is regarded as an abnormal condition and aberration of the harmonious order of the universe. Thus, those who become warriors must of necessity assume a changed psychological state in order to kill the enemy and win victory so as to restore harmony and balance in nature. However, after battle the community recognizes the need to return the warrior to a new role and identity in the culture. To do so the culture honors the warrior's acts of bravery and provides rituals to purge, purify, and heal the physical and psychological wounds of war. In addition to providing a supportive and caring milieu for the warrior, there is the awareness, often tacit and intrinsic to the group, that the warrior identity must be transformed into a new identity that demands maturity and responsibility. The failure to achieve this transformation of the warrior identity may lead to alienation and the assumption of a victimized state with debilitating psychological behaviors (e.g., alcoholism, depression, and self-destructiveness).



Generally, the shaman of the culture assumes the role of healer or medicine man and performs rituals of various types designed to cure suffering and restore good health and spirituality to the victim. Anthony F. C. Wallace (1966), the distinguished anthropologist, has written that

efforts to induce an ecstatic spiritual state by crudely and directly manipulating physiological processes are found in every religious system. Such manipulations may be classified under four major headings: (1) drugs, (2) sensory deprivation, (3) mortification of the flesh by pain, sleeplessness and fatigue, (4) deprivation of food, water and air. (p. 55)

The last three dimensions are commonly employed by various native American groups as part of healing and purification rituals, especially by the Lakota Sioux Indians in their sweat lodge ceremonies. Recently, Wilson (1985) has written on the efficacy and applicability of the sweat lodge ceremony as a form of treatment for PTSD, especially for war veterans. The sweat lodge ceremony possesses physical, psychological, group-oriented, and spiritual dimensions that are especially useful in treating PTSD. More precisely, these dimensions can be summarized briefly as: (1) transforming the warrior identity into a more generative mode (Erikson, 1968), (2) establishing individual and cultural continuity, (3) promoting self-disclosure while physically and emotionally bonded to others in an environment of intense heat, sensory deprivation, and shared collective pain. Table 1 summarizes the changes in PTSD symptom clusters produced by the sweat lodge ceremony.

In writing about various cultural and religious practices as a form of psychotherapy for the mentally ill, Wallace (1966) observes that they are designed to transform identity crises and maladaptive behavior.

These rituals of salvation are, in a sense, similar to rites of passage because they seek to effect a change in the career line of their subject; conversely, rites of passage, such as the Plains Indians' vision quest, may involve mystical phenomena in the course of identity change. The justification for setting aside a special category of salvation rituals lies in the fact that some identity crises are not universally anticipated in a society and are not treated with universally applied rites of passage, but rather are more or less ad hoc ceremonies performed by and upon only those persons who "spontaneously" enter into the experience for the sake of spiritual enrichment or salvation. . . . The function of ritual, in



TABLE 1  
The Effects of Sweat Lodge Purification Rituals  
on PTSD Among Vietnam Veterans

PTSD Dimension	Change in Symptom Cluster Produced by Purification Ritual
Depression, search for meaning, identity diffusion	Reformation of self, positive mood, enhanced sense of centering and identity
Physical symptoms, memory impairment	Tension release, relaxation, awareness focused on internal states, ability to concentrate
Stigmatization/alienation	Sense of unity, bonding, communality, and continuity
Anger/rage	Inner calmness, acceptance of fate, release of destructive thoughts
Sensation seeking/hyperarousal	Creative channeling of need to enhance feeling of vitality
Intrusive imagery/affective flooding	Reformulation of reason to enter ritual, transformation of imagery in less distressing direction, emotional calm
Intimacy conflict	Strong physical, psychological, and spiritual bonding
Isolation	Enhanced sense of unity, bonding, which contravenes isolation and aloneness
Emotional constriction/avoidance	Emotionally expressive, reduced numbing, counterphobic tendency reduced, interpersonal trust

Source: Wilson (1985).

these cases, is undoubtedly to provide a pattern for a process in remission of psychopathology which will bring the victim of a severe mental illness out "on the other side," . . . if the ritual is effective, he will arrive at a condition that will permit him to take care of himself and perform useful services (often ritual services) for the other members of the community. (p. 206-207)

Considering the perspective ritual transformations, we can ask how the sweat lodge ceremony facilitates a remission of PTSD and new vision of the self in society.



### *The Lakota Sweat Lodge Purification Ritual*

The Sioux Indian sweat lodge purification ritual\* is a religious event of thanksgiving and forgiveness which is typically led by a medicine man of the tribe. It is regarded as a serious occasion in which spiritual insights, personal growth, and physical healing may take place. The process of purification is physical, symbolic, and metaphysical.

*The sweat lodge.* The sweat lodge is a dome-shaped tent whose frame is constructed out of tree branches. The lodges vary in size and can hold between 7 and 20 men. The frame is covered with layers of blankets and topped with heavy canvas. The ground floor inside the dome is often covered with old carpeting or soft pine boughs to make the seating more comfortable. In the middle of the dome floor is a shallow pit, which has been dug out to a depth of about 4 to 12 inches. The pit holds rocks that have been heated in a fire located outside the sweat lodge. The opening to the lodge consists of a small door that is covered by a canvas flap. To enter the lodge the participants must kneel down and are instructed to crawl into the tent in a clockwise fashion. At the apex of the dome hang different colored cloth strips, which symbolize the sacred colors of the Sioux and the races of man.

Prior to the arrival of the participants a fire is made by placing about 16 to 30 rocks into a mound, which is encased by logs stacked upright in a conical shape. The fire is heated to a very hot temperature in preparation for the sweat lodge pit. Located between the fire and the dome are the ceremonial instruments, which include the sacred pipe, an eagle wing and feathers which lean against a small altarlike construction made out of Y-shaped supports, and a small tree branch which lies between them.

When it is time to begin the ceremony, the medicine man lights a small amount of sage in a bowl. The smoke is fanned by the participants over the head and chest to purify the body before entering the sweat lodge.

*The sweat lodge ritual.* Inside the sweat lodge the participants sit cross-legged in a tightly packed circle around the rock pit. Using the antlers of a deer, the medicine man places the first six rocks into the pit. These rocks represent the "six grandfathers," or the different powers

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\* The author has participated in 10 sweat lodges. The views expressed here are a reflection of these experiences.



of the universe. Additional rocks are added before the flap to the door is closed. The inside of the tent is now completely dark except for the dim glow from the red-hot rocks. The medicine man speaks in a calm and soothing voice about how good things can happen if everyone puts their minds together. He states that healing and purification can happen tonight and that the members can grow stronger by praying and overcoming pain and suffering. He explains that all the participants will suffer together in the intense heat and that all of life is a struggle with pain and suffering. Water is then ladled onto the rocks for each of the grandfathers as the medicine man sings a song of prayer, which is then sung collectively by the participants.

One by one, in a clockwise manner, each of the participants offers his individual prayer, which often begins with the words "Thank you, Grandfather" and ends with "Mitakuye oyasin" ("with all beings and all things let us be relatives"). During the ceremony there are "four doors," or four brief intervals during which the flap to the lodge is opened. The medicine man speaks words of wisdom and guidance at this time while the participants pass the wing of the eagle to fan themselves. Then, once again, there is darkness as the ceremony continues as more water is poured onto the rocks and the prayers resume. At the end of the "fourth door" the ceremony concludes as the individuals emerge into the cool air after spending an hour or longer in the sweat lodge. At this time the medicine man lights the sacred pipe, which is passed among the participants in a closing ritual.

### *Psychological Dimensions of the Ceremony*

When analyzing the psychological dimensions of the sweat lodge ceremony it must be recognized that each participant's perception and experience of the event will be affected by his unique personality characteristics, religious orientation, and cultural values. However, the ceremony does possess its own process and internal structure which bonds the participants together in a common group experience. In this regard, then, the sweat lodge ceremony contains a set of implicit psychological processes which involve group dynamics and individual modes of experience that are facilitated by the leadership and skill of the medicine man. To the student of group dynamics, much of what happens in the sweat lodge ceremony bears a great deal of similarity to group psychotherapy, intense interpersonal encounter, and other forms of social influence. On the other hand, it must be acknowledged that the scientific tradition of studying group dynamics may not be



sufficient when trying to understand the total reality of the ceremony, much of which is regarded as a spiritual encounter by Native Americans. Nevertheless, we believe that ritual is potentially a valuable therapeutic treatment for PTSD among victims who are not Native Americans.

Table 2 summarizes the dimensions of the sweat lodge ritual and their psychological effect. Elsewhere, Wilson (1985) has discussed the psychological aspects of the sweat lodge in more detail. However, owing to space limitations in this chapter, we shall briefly discuss the mechanisms by which the sweat lodge can serve as a therapeutic technique in treating PTSD among victimized persons, especially war veterans. And although it is undoubtedly the case that the ceremony is more powerful in terms of its symbolic and culturally specific meaning to Native Americans, it is our belief that it has a core psychological process that is universal in its effects. Although we do not wish to diminish the spiritual aspects of this ritual to Native Americans, it is believed that controlled scientific studies would demonstrate the efficacy of this ritual as a therapeutic tool for the treatment of PTSD (see Achterberg, 1985, for a fuller discussion).

Inside the sweat lodge there is sensory deprivation caused by the absence of light and extreme heat. As a result, attention becomes focused on one's inner state and the words of the other members as they pray. There is a lack of external stimuli and a struggle with the pain induced by the heat and cramped conditions. As the ceremony proceeds, there is typically a loss of a sense of time, near or actual dehydration, and many members report experiencing altered states of consciousness (see Harner, 1980, for a discussion).

The interior of the lodge creates a womblike environment that produces feelings of claustrophobia and an urge to escape. However, as the members are tightly packed in a circle, there develops a sense of being collectively joined and physically bonded (maternally reattached?) to others. It is difficult to move to change position. Thus, consciousness gets focused on one's inner state while listening simultaneously to the self-disclosure of the other participants. There is catharsis, the release of powerful emotion, and the acceptance of others as humans who are struggling with special pain. Perhaps for these reasons a sense of unity emerges out of the collective physical suffering and sharing of oneself with others. By the end of the fourth round, there emerges an enhanced sense of inner strength that one has overcome the pain, extreme heat, and darkness of the lodge to see new "light" in the self. The ritual is its own symbol and process: the members enter naked and crawl in a humble and humiliating position into the womblike tent. Then, through



TABLE 2  
Psychological Dimensions of Sweat Lodge Ritual

Dimension of Ritual	Psychological Effect
Sensory deprivation (lack of light)	Attention focused on inner state and words of others; lack of social cues and external stimuli; loss of time
Extreme heat	Struggle with pain, dehydration; altered states of consciousness
Small interior space	Womblike atmosphere; claustrophobic; urge to leave; no physical movement
Participants seated tightly in circle	Collectively joined and physically bonded
Individual prayers	Self-disclosure of personal concerns and needs; catharsis; acceptance of others; release
Four "doors" or rounds of prayer	Unity thema; collective suffering; collective sharing; enhanced sense of inner strength
Leadership of medicine man	Create expectations for healing; share wisdom of ritual; provide sense of continuity; role model of spiritual strength
Crawl in and out of tent naked	Humiliation; humbleness; smallness; release; rebirth; renewal

the guidance of the medicine man and the process of the four rounds of prayer, the members emerge again from the interior of the womb with a profound sense of release, rebirth, and personal renewal of spirit. Thus, as Table I summarizes, the dispirited state of PTSD is transformed by the ritual in ways that can be characterized as enhanced sense of centering, identity, connectedness, and emotional well-being.

#### PRECONDITIONS FOR EFFECTIVE PSYCHOTHERAPY WITH VIETNAM VETERANS

Based on 12 years of research and clinical work with Vietnam veterans who had high combat exposure, the following principles of therapy constitute the minimal conditions necessary to facilitate the stress recovery process and the proper therapeutic alliance between the client and the mental health professional.



### *1. Nonjudgmental Acceptance of the Veteran*

Vietnam veterans are especially sensitive about the complex aspects of their war experiences and are generally reluctant to talk about them. It is important that the therapist convey a nonjudgmental attitude about the person and what he did in the war, no matter how seemingly reprehensible, grotesque, or brutal. It is imperative that the clinician be open-minded and willing to learn about the trauma of war with all its absurdities, brutalities, and moral dilemmas. A corollary of this principle is that placing conditions of worth on the patient severely limits the possibility of creating a positive therapeutic alliance and helping the person come to terms with the painful legacy of war stress.

### *2. Willingness To Be Tested*

Many Vietnam veterans are reluctant to trust authority and will test the limits of the therapist in many different ways: intimidation, acting out, violation of rules, demands for self-disclosure by the professional, and "guerilla warfare" tactics applied to the therapeutic process. The clinician needs to be frank, honest, and appropriately self-disclosing without overidentifying with the patient in order to facilitate the therapeutic process.

### *3. Transference Is a Process of Symbolic Rebonding*

In the transference process the clinician is bonded by the veteran in trauma-associated ways. The transference process is complex and layered so that the clinician often symbolically represents: buddies from 'Nam, a commanding officer, a pre-Vietnam parental figure, or a partner in battle at the present time (i.e., the therapist and veteran are in war together vis-à-vis the stress recovery process).

Furthermore, the rebonding process is the essential condition for the development of deeper levels of trust which are necessary to work through the most painful and unresolved aspects of the war stress. The rebonding process counteracts purposeful distantiation and psychic numbing.

### *4. The Assumption of PTSD as Caused by War Stress*

Until a complete reconstruction of the individual history is achieved, it is helpful to assume that PTSD is caused by combat exposure and



war stress that overwhelmed the person's coping resources. Although premorbid factors frequently render the person vulnerable to stressors, the assumption of situationally produced PTSD facilitates the therapeutic alliance and rebonding process.

*5. The Assumption of Premorbidity in PTSD and Current Symptom Expression Will Be Counterproductive*

The clinician who views PTSD as a repression of neurotic anxiety or a character pathology will meet with strong resistance from Vietnam veterans. Furthermore, the clinician with a psychodynamic bias will be perceived by the client as fearful, reluctant, and unwilling to deal with intense affect, especially anger, as well as the disclosures of the horrors of war.

*6. PTSD Is a Transformative Process*

PTSD is a normal pattern of adaptation to abnormally stressful life events. Individuals with PTSD will progress through a predictable series of stages in the stress recovery process. Educating the client about the stages and symptoms of the disorder facilitates the therapeutic alliance and removes the stigma and fear of mental illness.

*7. Among Vietnam Veterans PTSD Is Part of Normative Identity Diffusion*

Among Vietnam veterans the stress of war produced deep and lasting changes in ego identity. For many, the Vietnam experience froze them in a time warp of the 1960s or early 1970s. Clinicians must recognize the need of many veterans of this era to hold onto old adolescent identity that existed before the war created identity diffusion. As noted earlier, many individuals fear that to give up either the warrior identity or the adolescent, pre-Vietnam identity is to face nonbeing or death. Thus, there is often regression to behaviors that characterize coping prior to the war or during it.

*8. PTSD Is Cyclical in Nature*

The stress recovery process is frequently cyclical in nature as ego controls determine the rate of assimilation of the trauma. As such, the



avoidance and intrusion cycles vary from person to person in their severity, length, and level of disruptiveness.

#### *9. PTSD Has a Psychogenic Amnesia Component*

Careful reconstruction of the client's war stress nearly always reveals psychogenic amnesia. The psychogenic amnesia is generally connected to the most troubling combat or war stress experiences. Psychogenic amnesia is frequently associated with affective flooding since there is a splitting off of the affect and the imagery (i.e., dissociation and repression of the material).

#### *10. Alcohol Abuse Severely Aggravates PTSD*

Alcohol abuse impedes the stress recovery process. Alcohol abuse blocks the individual's ability to feel the psychic pain necessary to motivate work in therapy. Additionally, excessive drinking is associated with: (1) states of disinhibition and hyperarousal, (2) sleep difficulties, (3) increased nightmares due to a loss of ego controls, (4) increased fatigue and decreased energy for coping, (5) states of rebound REM sleep with intrusive imagery and affective flooding, (6) feelings of loss of control and lowered self-esteem, and (7) decreased physical health. The clinician should explain the relation of alcohol abuse to PTSD in a straightforward manner. Treatment for alcoholism may be a necessity adjunct to other modes of therapy for successful recovery from PTSD.

#### *11. Locus of Responsibility for Recovery Rests with the Patient*

The clinician must mobilize the pain of the person in the recovery process by focusing responsibility for change onto the individual. The therapist must also be aware of problems of countertransference and therapeutic traps, which include: overidentification, overcommitment, over-involvement, guilt over not serving during the war, superficial focusing on war stories, interpreting too early, making moral judgments about actions of the client during the war, and avoidance of hearing about grotesque realities of guerilla warfare.

#### *12. The Recovery Process Entails the Development of Concrete Goals*

The return to positive coping and adjustment requires that the patient develop realistic and attainable concrete goals in terms of occupation,



intimate relations, interpersonal relations, and the management of stress. Since PTSD frequently has been associated with the development of negative or self-destructive coping behaviors, it is important that follow-up checks be made to monitor progress and to guard against a return to avoidant or maladaptive actions.

### *13. The Struggle with PTSD Often Results in Positive Character Traits*

Out of the struggle to reformulate and transform the impact of the traumatic event on the self, the individual often develops many good values and character traits. Among the many attributes common to survivors are: honesty, integrity, sensitivity, acceptance of others, concern with justice and equality, nonmaterialistic world view, inner strength, spirituality, and the profound awareness of the basics in life. The clinician should help patients become aware of the many virtues and positive character traits that exist. So often the victim's self-image is clouded by the trauma that their self-perspective is distorted and blocks the recognition of good qualities.

### *14. Prosocial Action Facilitates the Recovery Process*

Research evidence (Gleser et al., 1981) indicates that involvement in events of a prosocial nature is associated with the stress recovery process. As paradoxical as it seems, helping others appears to have a stress-reducing or stress-buffering effect. Although there are undoubtedly many possible explanations for this effect, at a minimum the person is diverting attention away from the self while performing in a helpful way to others that leads to social reinforcement as well as to feelings of efficacy.

### *15. Recovery from PTSD Is a Lifelong Process*

It is rare for extreme traumatic episodes to be short-lived. Extreme stress leaves a psychic legacy that may require years of processing before it no longer debilitates the individual. It is also the case that it will, to some degree, affect each stage of the aging process and thus express itself during life crises and transitions, such as the birth of a child, retirement, or loss of a loved one. The clinician working with victims needs to be sensitive to the subtle unconscious expression and return of trauma-related symptoms. Indeed, after many years of freedom from thoughts of the traumatic life event the person may feel especially vulnerable or anxious if he or she becomes symptomatic again. The



clinician should explain that this is both normal and common. Reassurance that the episode was probably triggered by a life crisis or mundane event will help to bind the anxiety and implement proper controls.

## CONCLUSION

History teaches us that it takes many years to come to a well-balanced and accurate analysis of the antecedent factors and consequences of a particular war. So, too, it may take many years of careful, longitudinal study to ascertain the effects of war in the lives of those who experience it directly as well as the impact it makes on society. However, the accumulated body of reliable clinical, research, and epidemiological data on the psychological effects of the Vietnam War point to the possibility of long-term psychosocial and psychiatric effects that are currently being discussed under the rubric of post-traumatic stress syndromes.

In summarizing, several central concepts can be placed into perspective. First, the understanding of post-traumatic adaptation requires a comprehensive theory of the factors that are associated with alternative paths of postwar coping and adaptation. This model of adaptation must be interactive in nature and specify as precisely as possible: (1) the nature of the traumatic event and the unique stressors experienced in it, (2) the personality and coping mechanisms of the individual before, during, and after the trauma, (3) the nature of the recovery environment in terms of support networks and social programs designed to facilitate the assumption of stable functioning and personal responsibility, (4) the sequential stages of post-traumatic cognitive processing which are affected, to varying degrees at varying levels, by other codetermining variables.

For the youthful soldier who fought in Vietnam the war was a complex, surrealistic environment, often horrifying, full of existential, moral, and spiritual dilemmas. It was also an exciting, challenging, and intense experience shared in common bond with buddies locked into the same fate. To be sure, the arena of warfare was difficult: adversarial warriors seeking victory in ancient jungle battlegrounds that were the enemy's homeland. Here the Viet Cong and North Vietnamese forces fought for political sovereignty and ideological goals. The day-to-day realities of combat took on the dramatic quality of Joseph Conrad's novel *The Heart of Darkness*. Soon the language of the U.S. military began to reflect the face of guerilla warfare: search-and-destroy oper-



ations, landing zones, air mobile combat assault, area of operations, insertion and extraction of air mobile infantry units, special-forces counterinsurgency operations, short-timer, DEROS date, medevac, starlight scopes, defoliation, body counts, mobile guerilla forces, and much more. Stated in different terms, the Vietnam War was not a conventional war and because of that there were multidimensional stressor events that could and did overwhelm the protective shield of the vulnerable ego defenses of 19-year-old warriors. For many the exposure to heavy combat, replete with ambushes, fire fights, mortar bombs, booby traps, sniper attacks, etc., often resulted in the task of somehow making sense of why all of this was happening. Clearly, wars always leave lasting imprints in memory of the grotesque and brutal consequences of injury, killing, and destruction. The critical question, of course, centers around how difficult the stress recovery process would be. In the case of Vietnam veterans the answer can be stated unequivocally: the conditions of the times could not have been worse in terms of facilitating the stress recovery process. To quote an earlier work (Wilson, 1980):

If you were demonic and powerful enough to want to make someone "crazy" following a war like Vietnam, what would be the worst set of social, economic, political, and psychological conditions you could create for the returnee?

First, you would send a young man fresh out of high school to an unpopular, controversial guerilla war far away from home. Expose him to intensely stressful events, some so horrible that it would be impossible to easily talk about them later to anyone else except fellow "survivors." To ensure maximal stress, you would create a one-year tour of duty during which the combatant flies to and from the war zone singly, *without* a cohesive, intact, and emotionally supportive unit with high morale. You would also create the one-year rotation to instill a "survivor mentality" which would undercut the process of ideological commitment to winning the war and seeing it as a noble cause. Then at DEROS (Date of Expected Return from Overseas Service) you would rapidly remove the combatant and *singly* return him to his front porch *without* an opportunity to sort out the meaning of the experiences with the men in his unit. No homecoming welcome or victory parades. Ah, but yet, since you are demonic enough, you make sure that the veteran is stigmatized and portrayed in the public as a "drug-crazed psychopathic killer." By virtue of clever selection by the Selective Service system, the veteran would be unable to easily re-enter the mainstream of society because he is undereducated and lacks marketable job skills.



Further, since the war itself was so difficult, you would want to make sure that there were no supportive systems in society for him, especially among health professionals at VA hospitals who would find his nightmares and residual war-related anxieties unintelligible. Finally you would want to establish a GI Bill with inadequate benefits to pay for education and job training, coupled with an economy of high inflation and unemployment.

Last, but not least, you would want him to *feel* isolated, stigmatized, unappreciated, and exploited for volunteering to serve his country.

Tragically, of course, this scenario is not fictitious; it was the homecoming for most Vietnam veterans.

Today there are hundreds of thousands of Vietnam veterans, men and women, who have in the past or are currently suffering from PTSD. As described in this chapter, PTSD is a complex psychological reaction to extreme stress. Its hallmark features are reliving elements of the traumatic event in nightmares, distressing intrusive imagery, avoidance, affective flooding, and hyperarousal states. Additionally, these are typically associated with the central mechanisms of reexperiencing the trauma, as well as the symptoms of depression, search for meaning, identity diffusion, anger, rage, emotional constriction, psychic numbing, intimacy conflict, stigmatization, alienation, and positive or negative changes in character structure and adaptive behavior. The stress recovery process from PTSD characteristically follows through a predictable sequence of stages, which begin with denial and intrusive imagery and end with the restoration of adaptive controls that allow the traumatic experiences and the self-structure to be congruent with each other.

Traumatic events can transform pre-trauma personality characteristics by producing: (1) positive, adaptive character strengthening, (2) negative, maladaptive character disorder, (3) intensification of stage-specific stages of ego development, (4) the development of PTSD without a personality disorder in an individual with no previous history of character pathology, (5) the development of PTSD and character pathology or other mental disorders. Moreover, one of the central difficulties in achieving an accurate differential diagnosis lies in the fact that many of the diagnostic criteria for PTSD overlap with other diagnostic criteria, such as those for schizotypal, borderline, and paranoid personality disorder.

Although much has been learned in the last 15 years of social science research on Vietnam veterans, there are many unanswered questions that remain to be raised and systematically studied. Clearly, a task of the future will be to address these questions in a spirit of humane



commitment to understanding not only how war affects those who survive it, but the processes that facilitate healing, growth, and the restoration of human integrity and dignity.

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# 13

## *Treating Survivors and Children of Survivors of the Nazi Holocaust*

Yael Danieli

The following is excerpted with minor corrections, from a letter written by a survivor, E. Z., in which he refers to the intergenerational community meetings,\* one of the several therapeutic modalities offered by the Group Project for Holocaust Survivors and Their Children:

It just occurred to me that I should let you know how grateful I am that I . . . join[ed] your wonderful [Project] even if the occasion for meeting the group was a sad one, the memorial for J. L.

During the . . . meetings I attended I realized how important your work is in helping survivors and their family members to cope with one form or other of trauma. . . .

It gives me a great satisfaction to know that J. L. received in the last few months of his life, from you and your group, the moral and spiritual support which eluded him for such a long time while he tried to get it from [so] many [others]. . . . But as J. L. once said, so much is done and spent to memorialize the

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\* Intergenerational community meetings are one of several group experiences offered by the Group Project for Holocaust Survivors and Their Children (Danieli, 1981f, 1985c). This particular type of meeting is held every two months for all Project participants, survivors, children of survivors, their families, and newcomers, all of whom are invited, free of charge, to share mutual past and present concerns.



dead but there is no concern for the living suffering survivors. [From his experience with the Project he] learned that that is not entirely so. . . .

As for me, I felt at the meeting almost as if I fell into a big family whose members, individually and collectively, give each other support and advice and share their problems and troubles and joys, with an occasional minor quarrel or criticism thrown in.

I do not wish to miss a meeting if I can help it because there is love in the group and concern for the next one. One cannot ask for much more. . . .

The Group Project for Holocaust Survivors and Their Children was established to counteract the profound sense of isolation and alienation among Holocaust survivors and their children—the most common consequences of the pervasive *conspiracy of silence* about their victimization histories which has existed between survivors, their children, and society since the end of World War II as a result of the pervasive negative societal reactions and attitudes, such as indifference, avoidance, repression, and denial of their Holocaust experiences, that most survivors encountered after the war. The project was established to compensate for their neglect by the mental health profession—which stemmed from the conspiracy of silence between these individuals and psychotherapists, both referred to in E. Z.'s letter above.

From its inception in 1975 by volunteer psychotherapists in the New York City area, the Project has recognized the vital importance of self-help and specialized training toward these goals and has capitalized on group and community therapeutic modalities. By participating in groups, survivors and children of survivors could at last talk about their memories and experiences. They were also able to explore with each other and comprehend the long-term consequences in their lives of the Holocaust and the conspiracy of silence that followed it, and share their feelings and current concerns (Danieli, 1982b).

A comprehensive review of the literature on the conspiracy of silence between survivors and society in general, and survivors and mental health professionals in particular, its impact on the survivors, their families, and their psychotherapies, and of the author's own research on therapists' difficulties in treating survivors of the Nazi Holocaust and their children, may be found in Danieli (1982a, 1984).

Some excellent reviews of the psychiatric literature on the long-term effects of the massive traumata experienced by these remnants of European Jewry and of their treatment can be found in articles in Krystal



(1968), Krystal and Niderland (1971), Chodoff (1975), Rijswijk (1979), and Dimasdale (1980), among others. Only in 1980 did evolving descriptions of the "survivor syndrome" in this literature find their way into the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, pp. 236-238) as a separate, valid category, post-traumatic stress disorder.

Literature on the intergenerational transmission\* and treatment of the psychological effects of the Holocaust on survivors' offspring (children born after the war) began with Rakoff's article (1966). A review of this literature and an up-to-date bibliography can be found in Wanderman (1979), Bergman and Jucovy (1982), and Daniell (1981c, 1982a, 1985b). Recently, concern has also been voiced about the transmission of pathological intergenerational processes to the third and succeeding generations (for example, see Rosenthal and Rosenthal 1980). The recognition of possible intergenerational transmission of victimization-related pathology still awaits admission in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Until then, the behavior of some children of survivors may be misdiagnosed, its etiology misunderstood, and its treatment, at best, incomplete.

#### PSYCHOTHERAPY WITH HOLOCAUST SURVIVORS

Reviewing the literature on psychotherapy with survivors, Chodoff (1975, 1980) concluded that (with some exceptions) the prevailing tone, especially in the analytically oriented articles, "emphasizes the obstacles and difficulties in the way of successful psychotherapy with [survivors] and [agrees] that goals of psychotherapy should be relatively limited, oriented toward support and symptom relief rather than toward reconstructive goals" (1975, p. 944).

Krystal (1981), writing about aging survivors of the Holocaust in particular, stated that his findings basically coincide with those reported by others and summarized major obstacles affecting the survivors' attempts at "posttraumatic healing and mastery of the intrapsychic injuries," as well as the revision and evaluation of their lives in their

\* "Intergenerational transmission" refers to behaviors of survivors' offspring (children born after the war) which are dynamically assumed to have their origins either in symbolic relationship to their parents' Holocaust experiences or to be shaped by their parents' Holocaust-related pathogenic behaviors.



old age. According to Krystal, the most crucial of the "posttraumatic constellations" resulting from catastrophic adult psychic trauma are alexithymia and anhedonia. In 1979 Krystal stated: "The two cardinal signs and problems of alexithymia are: (1) Affective: Emotions are undifferentiated, mostly somatic and poorly verbalized. Affects are not utilizable as signals to oneself, and patients cannot tell how they feel. The 'expressive,' i.e., physiological aspects of emotions manifest themselves as troublesome sensations or psychosomatic illnesses. (2) Cognitive: The thinking is 'operative'" (p. 29). There is an exaggerated emphasis on the banal and mundane details of the "things" and "facts" in their lives and a concomitant severe impairment and constriction of the capacity for wish fulfillment and drive-related fantasy. In 1982 Krystal stated: "They also have a seriously diminished emotional involvement with [others] and a lowered capacity for empathy [trust and experiencing love]. . . . There are frequently associated problems such as . . . impairments in the capacities for self-care, and affect tolerance" (p. 353). Other aftereffects he noted are: survivor guilt; shame; difficulties in management of rage; qualitative and quantitative deterrents to working through their losses; and excessive use of repression, denial, psychic splitting, and "externalization."

Some of the pessimism voiced in the above literature about helping survivors may be due to its primarily intrapsychic bias and psychoanalytical orientation. This perspective largely ignores acknowledging the Holocaust as a group phenomenon and the central role of "we-ness" in the survival and the identity of its victim/survivors, a characteristic that should be considered in treatment goals, techniques, and modalities.

In providing individual, family, group, and intergenerational community assistance, the Group Project for Holocaust Survivors and Their Children typically avoids institutional settings. Survivors' resistance to institutions—their fear of being stigmatized, labeled crazy (stemming from the Nazi practice of gassing the sick or mentally ill), or considered emotionally damaged by their victimization—specifically precluded making the Project part of a mental health facility. In general, physical problems were far more acceptable to these families than psychological problems. The latter threatened the parents' need to deny the Holocaust's long-term emotional effects, which they viewed as evidence of Hitler's posthumous victory. Worse, openly acknowledging their own psychological problems or those of their children diminished their self-image as perfect parents and their view of their offspring as "perfectly normal."

The Project's goals, which are preventive as well as reparative, are predicated on two major assumptions: (1) that integration of Holocaust



experiences into the *totality* of the survivors' and their children's lives and awareness of the meaning of post-Holocaust adaptational styles (Danieli, 1981a, 1981c) will liberate them from the trauma and facilitate mental health and self-actualization for both; and (2) that awareness of transmitted intergenerational processes will inhibit transmission of pathology to succeeding generations.

### THE IMPORTANCE OF PREWAR HOLOCAUST HISTORY FOR TREATMENT

It is critical to consider pre-Holocaust background to understand postwar adjustment. This includes the characteristics and dynamics of the survivor's family of origin in the pre-World War II European Jewish life in its heterogeneity and such demographic factors as the nationality, age, education, occupation, and marital and social status of the survivor at the onset of the Holocaust. These should be explored in psychotherapy with survivors and their children in order to (re)establish the sense of integration, rootedness, and continuity so damaged by their traumata. Therapy should also allow these individuals to discuss the meaning of being a Jew and the belief in God before and after the Holocaust (Danieli, 1981b, 1984).

Knowledge about the Holocaust greatly increases the therapist's ability to help survivors and their offspring. Although information cannot undo unconscious reactions in either the therapist or the patient, it does provide a frame of reference that helps the therapist to know what to look for and what types of questions to ask.

Familiarity with the growing body of literature on the long-term psychological sequelae of the Holocaust on its survivors and their offspring helps in the same fashion. Nevertheless, mental health professionals should guard against the simple grouping of individuals as "survivors" who are expected to exhibit the same "survivor syndrome" (Krystal & Niederland, 1968) and the expectation that children of survivors will manifest a singly transmitted "child of survivor syndrome" (e.g., Phillips, 1978). Indeed, the heterogeneity of the responses to the Holocaust and post-Holocaust life experiences in families of survivors, (Danieli, 1981a; Rich, 1982; Sigal, 1985) suggests the need to match appropriate interventions to particular forms of reaction and to respect the unique individuality of each survivor or offspring if optimal therapeutic or preventive benefits are to be obtained.

Children of survivors seem to have consciously and unconsciously



absorbed their parents' Holocaust experiences into their lives. Holocaust parents, in the attempt to give children their best, taught them how to survive and in the process transmitted to them the life conditions under which they had survived the war. Thus, one finds children of survivors who psychologically, and sometimes literally, live in hiding. Others are always ready to escape or continuously run from relationships with people, from commitment to a career, or from one place of residence or country to another. Some keep split or double (fake) identities. Others adopt a resigned, "Musselman" \* passivity as their mode of being in the world-camp. We see tireless manipulators and those who, in whatever they do, are resistance fighters. These modes of being are manifested in their language, behavior, fantasy life, and dreams.

Like their parents, many children of survivors manifest these Holocaust-derived behaviors, particularly on the anniversaries of their parents' traumata. Moreover, some have internalized as parts of their identity the images of those who perished and hence live in different places (Europe and America) and different time zones (1942 and the present) simultaneously. The individual survivor's family tree and (war) history are crucial to understanding the survivor's offspring and should be explored in detail in their psychotherapies to help them separate and find their own identities.

#### SEPARATION AS A PIVOTAL DIFFICULTY

Holocaust experiences render the normal process of separation a highly complex and arduous problem in survivors' families. During the war, being separated meant total and permanent loss. This meaning still pervades anything that may, consciously or unconsciously, represent a threat to the intactness of the family. A 30-year-old married daughter, reflecting on her difficulty in separating psychologically from her parents, stated poignantly, "When my mother separated from her mother [in Auschwitz], her mother went to the left [to the gas chambers] and my mother went to the right. How could I possibly do anything like that?" Another child of a survivor constantly prevented or destroyed his success because "surpassing [his] parents means leaving them behind, to die." Therapists, often viewed as encouraging separation, must confront the

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\* This term, taken from the German, was used by concentration camp inmates to describe those among them who gave up and, usually, died.



family's perception of them as Nazis and be able to contain both the family's and their own emotional reactions.

Most of these families are extremely small. The Holocaust deprived them of the normal cycle of the generations and ages, and of natural death (Eitinger, 1980). Each family tree is laden with murderous deaths and losses. Indeed, the most painful and intolerable struggle underlying all attempts at coping with and integrating the impact of the Holocaust into the lives of these families is the *genuine impossibility of mourning*. As one 74-year-old woman, recently widowed again and the sole survivor of a family of 72 people, put it, "Even if it takes one year to mourn each loss, and even if I live to be 107 [and mourn all members of my family], what do I do about the rest of the six million?"

Psychological/internal liberation from the trauma of victimization and its effects is the ultimate goal of treatment for survivors and their children, and *integration* is its central and guiding dynamic principle. Such integration can only be achieved through a full longitudinal perspective of the victimization experiences and their impact on one's life space at any point in time. An essential aspect of the establishment of such perspective is that when we speak of integration for severely victimized people, we speak of integrating the *extraordinary* into one's life—that is, confronting and incorporating aspects of human experiences that are not normally encountered.

Victimization causes a rupture in the ordinary free flow of life and a state of being "stuck," which I have called *fixity*. The time, duration, extent, and meaning of the victimization for the individual, as well as adverse postvictimization experiences (including the conspiracy of silence or second wound [Symonds, 1980]), determine the elements and degree of disruption, disorganization, and disorientation, and the severity of the fixity. The massive catastrophe of the Nazi Holocaust not only ruptured continuity, but also destroyed all the individual's existing supports. The conspiracy of silence exacerbated the situation by further depriving the victim/survivor of potential supports.

For these individuals especially, recovery and rehabilitation, and thereby freeing life's flow may rarely have the meaning of "going back to normal." This is true in terms of (re)adapting to "normal society" and of returning to prior ways of being and functioning. In fact, the hope of resurrecting their (now often idealized) previous lives is unrealizable. Moreover, clinging to such a hope attests to attempted denial of their Holocaust and postvictimization experiences and their significance, and thereby to fixity.

Fixity also occurs when survivors are solely preoccupied with their



Holocaust experiences: "I can't think of anything else. There is nothing to live for after what happened to us." Still others compulsively cling to current concerns and live vicariously through their children. An example follows:

"I keep myself busy so I don't think. My life doesn't matter. It is all for the children. If they are happy, I am happy. When she [her daughter] does these things, I feel more upset than I felt in Auschwitz. Auschwitz doesn't matter."

Mrs. B. experienced her daughter's rather average adolescent behavior as total loss and abandonment and could not stop "obsessing over them" though her daughter was now in her thirties and divorced. A slip of the tongue during therapy, when Mrs. B. referred to her daughter by her murdered sister's name, helped decipher both the events Mrs. B. was reliving and the source and intensity of her feelings. Letting herself remember the last time she saw her sister and feel the acute bitter pain of "never [having] said goodbye" to her or to her parents and her utter helplessness about helping them led to a number of sessions where she, after years, told of her childhood in the direction of reviewing and reowning the totality of her life.

The most immediate consequence in terms of her current family life was her growing ability to "give more space" to her two children and husband yet, at the same time, to share more, and more genuinely, of herself with them. After a family session, the daughter, in her therapy, began to comprehend both her own sense of burden, guilt, and helpless rage and the meaning of her mother's need to control and to know her every move. While becoming better able to express her anger about her "Nazi mother" (for a discussion of affect tolerance in children of survivors, see Wilson, 1985), real compassion for her also grew, as did her curiosity about her family tree in general and the murdered aunt she has (unconsciously) represented and "replaced" for her mother in particular.

In time it became clear that much of the mother's fixity (on being always busy and "upset" in her post-Holocaust present) served as a defense against her uncontrollable rage against the Nazis; her shame and fear about her identification with them and about viewing her daughter as a Nazi and her sister and herself as deprived adolescents, and her frozen grief and mourning (see also Krystal, 1975, 1978).

Family members reported relief and a sense of liberation upon comprehending the parallels of their behavior and feelings with the parents' victimization experiences and with their history and family tree. This



is especially true after those phases of treatment which allowed "exorcism" of the Nazis out of the family, "invited" and "introduced" murdered family members through Gestalt and psychodrama techniques, and began the process of mourning and successful integration.

Had the therapist complied with this mother's original stated refusal to talk about the Holocaust, she would have reinforced Mrs. B.'s fear that, to this day, it still has the power and the destructive force to do to the B. family what it did during the war, and that there is no way to contain and work through the feelings associated with this part of their history. Therapists who comply with survivors' reluctance to talk about their pre-Holocaust life ("It was all destroyed") participate in depriving them of the prolife forces and sense of rootedness and belongingness originating from that period of their lives.

The task of therapy, then, is to help survivors and children of survivors achieve integration of an experience that has halted the normal flow of life. Indeed, when psychotherapy dwells on certain periods in survivors' lives and neglects others, it hinders survivors and their offspring from meaningfully recreating the flow within the totality of their lives and may perpetuate their sense of disruption, discontinuity, and rootlessness (see also de Wind, 1972; Lifton, 1973, 1979).

Integration and recovery involve the victim/survivor's ability to develop a realistic perspective of what happened, by whom, to whom, and to accept the reality that it happened the way it did, what was and was not under his or her control, what could not be and why. Accepting the impersonality of the events also removes the need to attribute personal causality and the consequent guilt and false responsibility. An example follows:

When Mrs. K. first came to treatment with her husband "because M. [their daughter] wanted [them] to," she had "nothing to say." She was "half dead, half alive" and had never told her Holocaust story to her husband, himself also a survivor. Lack of communication and constant bickering about mutual disappointments, common in many survivors' marriages, characterized their relationship. The only survivor of her family, Mrs. K. also seemed to envy her husband, who had one brother who survived and an aunt who escaped to the United States before the war, who, though distant, created a semblance of a family for him in Mrs. K.'s eyes.

Mrs. K. was always suffering from physical pains, some directly related to being tortured, beaten, and kicked, in addition to the usual conditions



of living in the camps. However, she neither complained to anyone nor sought medical help for her suffering. She also never completed her application for German restitution.

The turning point in Mrs. K.'s treatment came when she "confessed" that she had been married and had given birth to a baby in the ghetto whom she "gave to the Nazis." Her guilt, shame, and feeling "filthy" were exacerbated when she was warned after liberation by "well-meaning people" that if she told her new fiancé, he would never marry her. The baby, whom she bore and kept alive for two and a half years under the most horrendously inhuman conditions, was torn from her arms and murdered when his whimper alerted the Nazi officer that he was hidden under her coat, after she had already passed the selection for deportation and was sent to the right (to work).

As in Mrs. B.'s case, the K. family also started sharing their history and communicating. It took about six months, however, of patient requests for her to repeat the above incident, in particular ("realistic" and "rational" attempts at convincing a survivor of his of her innocence tend to provide only a momentary relief at most, especially in the long-term and intergenerational cases), until she was able to end her ghetto story with "and they took the child away from me." She then began to thaw her identificatory deadness and experience the missing accompanying emotions of pain and grief and the realization of her existential helplessness and hatred, moving ultimately toward living fully in the present.

Much of Mrs. K.'s healing process capitalized on sources of goodness and strength before and during the war, such as her spunk as a child, her ability to dream of her grandfather consoling her when she gave up in the camps, her warmth, intelligence, wonderful sense of humor, and reawakened sense of delight. In her case, her ability and longing to love were really resurrected. She fell in love with her husband, and they have made vacations a regular part of their lives. Initially a shy, isolated, and extremely depressed couple, they have become assertive and have taken an inspirational, leadership position in the Project's community, as well as in Mr. K.'s township meetings. No longer formally in therapy, Mrs. K. says, "I have myself back, all over again. . . . I wasn't proud. Now I'm proud. There are some things I don't like, but I have hope."

An educated and contained image of the events of one's life before, during, and after victimization potentially frees one from constructing a view of oneself and humanity solely on the basis of the victimization



events. For example, having been helpless does not mean that one is a helpless person; having witnessed or experienced evil does not mean that the world as a whole is evil; having been betrayed does not mean that betrayal is an overriding human behavior; having been violated does not necessarily mean that one has to live one's life in constant readiness for its reenactment; having been treated as dispensable does not mean that one is worthless; and taking the painful risk of bearing witness does not mean that the world will listen, learn, change, or become a better place.

Long-term treatment attempts to help participants "get better" rather than just "feel better." "Getting better," acquiring adaptive, productive patterns of functioning in life, involves a continuous and constant unraveling and working through of the (unconscious) rigidified and self-perpetuated victim/survivor context or stance.

The diagnostic and therapeutic use of constructing a three-generation family tree with survivors and their offspring, although it triggers an acute sense of pain and loss, serves to recreate a sense of continuity, so damaged by their Holocaust and post-Holocaust experiences. Whether family therapy is feasible or not, viewing the individual within the dynamics of his or her family system and culture is of great therapeutic value. Furthermore, combining therapeutic modalities is especially helpful in working through long-term and intergenerational effects of victimization.

Certain features of the survivor and his or her past should be fostered in the course of therapy. These involve general cognitive abilities and elements of one's active control and mastery in the act of survival and the rebuilding of life, such as hope, determination, courage, loyalty, humor; and sources of support and love in one's memories and current life. These features nurture one's ability for self-soothing; trusting, experiencing, accepting and giving love and help; and attaining a sense of wholeness, healing, and recovery. These must develop if the survivor is to gain perspective and to integrate other elements of his or her Holocaust or other victimization experiences, such as evil, hate, murder, brutality, destruction, injustice, indifference, chaos, helplessness, degradation and humiliation, shame, rage, loss, shattered trust, and unbearable grief.

### SURVIVOR GUILT

The distortion caused by insufficient understanding of the meaning and functions of the experience of *survivor guilt* is one of the most



poignant instances of how extraordinary human experience challenges and exposes the limits of traditional psychological theories of ordinary life. Elsewhere (Danieli, 1984), I stated that the pervasiveness of *by-stander guilt* among psychotherapists and researchers may account for what I feel is their overuse, stereotypical attribution, and reductionist misinterpretation of concepts such as "survivor's guilt," which Niederland (1961, 1964) and Krystal and Niederland (1968) described as a major feature of the "survivor's syndrome."

In the process of therapy, therapists often misconstrue the functions and meanings of their patients' experience and expression of survivor's guilt as a manifestation of resistance or negative therapeutic reaction. As a result, they tend to become intolerant of their patients' apparent "stubborn" suffering, which often leads to therapeutic impasses, or worse, to termination of treatment. I will, therefore, point to some of the central meanings and functions of guilt in the survivors or their offspring.

One of the most powerful functions of survivor guilt is to serve as a defense against intolerable existential helplessness. Being totally passive and helpless in the face of the Holocaust is perhaps the most devastating experience for survivor/victims. Elsewhere (Danieli, 1981a, 1981b) I have speculated that much of what has been termed "survivor guilt" may be an unconscious attempt to deny or undo this passive helplessness. Guilt presupposes the presence of choice and the power, ability, and possibility to exercise it. Guilt states, "I chose wrong. I *could* have done something [to prevent what happened] and I didn't," or "There is something I *can* do and if I only tried hard enough I will find what it is."

Guilt as a defense against the experience of utter helplessness links both generations to the Holocaust. The children are helpless in their mission to undo the Holocaust both for their survivor parents and for themselves. This sense of failure is often generalized as "No matter what I do or how far I go, nothing will be good enough."

In addition, survivor guilt is a way of working through late mourning and bereavement for loss of beloved people. According to Klein (1968), "it also seems to serve as a means of survival in a chaotic world where all objects of love have been lost and where there are no people with whom to cry and to share one's grief" (pp. 234-234). Survivors fear that successful mourning may lead to letting go, thereby to forgetting the dead and committing them to oblivion, which for many of them amounts to perpetuating Nazi crime. Thus, guilt also serves a commemorative function and as a vehicle of loyalty to the dead (see also Sterba, 1968). In Elie Wiesel's words (1979), "they have no cemetery;



we are their cemetery." Many children of survivors also share this sentiment and, like their parents, hold on to the anhedonia, guilt, shame, and pain related to their family history during the Holocaust and its consequences: "I feel the pain that my mother and father went through. If I don't, I am a disloyal son."

Counteracting psychological aloneness and reestablishing and maintaining a sense of belongingness and (familial/social and cultural) continuity are two additional crucially important functions of survivor guilt. One survivor stated, "How can I be happy, knowing that they [family] are not here to celebrate with us?" And another survivor commented, "If we accept the ashes, then we have no past."

One of the most adaptive functions of survivor guilt is to serve as a reaffirmation of morality and of the world as a just and compassionate place. Klein (1968) views it as "restitution of lost human values, as well as restoration of one's own human image." He states that "both guilt and aggression serve to restore a feeling of justice and security in relation to the world," which is "in complete contrast . . . to the denial and rejection of any kind of guilt by the mass murderer . . ." and the silently acquiescent world (pp. 234-235; see also Chodoff, 1981). The need and determination of many survivors and survivors' offspring to bear witness expresses both their commitment to make the world a better place where atrocities such as the Nazi Holocaust will never happen again and their belief in the moral compassion and responsive participation of their listeners.

The therapist's full understanding and acceptance of the meaning of survivor guilt within the therapeutic process is crucial in aiding the victim/survivor to constructively transcend it. The same principles hold for helping the victim/survivor to constructively transcend the crippling effects of *identification with the aggressor*.

Our work has shown that allowing the victim/survivor to express him/herself in the language primary to their (pre)victimization experience is helpful, even if the therapist does not understand it and must await a translation. In determining placement of treatment, therapists should also be aware of the symbolic meanings of the therapeutic setting and/or the symbolic function of medication for the victim/survivor in order not to trigger reenactments of victimization experiences, and in order to understand the victim/survivor's response to them. For example, hospitalization may be experienced as an incarceration and medication as a return to helplessness. For issues and concerns specific to aging survivors, see the special issue of the *Journal of Geriatric Psychiatry*, "The Aging Survivor of the Holocaust" (Blau & Kahana, 1981).



## THE GROUP MODALITY

The unique reparative and preventive value of the group modality in meeting the needs of survivors and their offspring cannot be overemphasized. First, group and community therapeutic modalities counteract their sense of alienation and isolation and affirm the central role of "we-ness" and the need for a collective search for meaningful response (Danieli, 1985c). These modalities also help rebuild a sense of extended family and community, which were lost during the Holocaust.

Group modalities have also helped psychotherapists compensate for and moderate their own difficulties in treating survivors and children of survivors. Whereas a therapist alone may feel unable to contain or provide a "holding environment" (Winnicott, 1965) for his or her patient's feelings, the group as a unit is able to. While any particular intense interaction invoked by victimization memories may prove too overwhelming to some people present, others invariably come forth with a variety of helpful "holding" reactions. Thus, the group functions as an ideal absorptive entity for abreaction and catharsis of emotions, especially negative ones, that are otherwise experienced as uncontainable.

The group offers a multiplicity of options for expressing, naming, verbalizing, and modulating feelings. It is a safe place for exploring fantasies, for imagining, "inviting," and taking on the roles of murdered relatives or victimizers, and for examining their significance in the identity of group members. Identifying and observing others' victimization-derived behaviors help group members recognize their own and enable them to use peer confrontations for change. They can safely test new behaviors and receive feedback about their impact on others. The group also encourages and demonstrates mutual caring, which ultimately enhances self-care in survivors and their families. For an evaluative description of the six types of groups offered by the Group Project for Holocaust Survivors and Their Children, see Danieli (1981f, 1985b, 1985c).

In reflecting on the contents of this chapter, I realize that what I have proposed is what has been described as good therapy throughout the history of the discipline (see also Hoppe, 1968). The need to reiterate these factors as the goals and principles of working with survivors of the Nazi Holocaust and their offspring perhaps attests to the crippling effects of countertransference, which often renders the therapist unable to listen, a necessary condition for fulfilling his/her therapeutic contract. My systematic examination (Danieli, 1982a) of psychotherapists' "coun-



tertransference" reactions and attitudes strongly suggests that the source of these reactions is the Holocaust, rather than the actual encounter with its survivors and their offspring. Attending or attempting not to attend to the extraordinary evil of victimization seems to override therapists' concern with the unique individuality of their patients. Our work calls on us to confront, with our patients and within ourselves, extraordinary human experiences. This confrontation is profoundly humbling in that at all times these experiences challenge the limits of our humanity and our view of the world we live in. No matter how overwhelmingly tragic and painful, or how shocking and shameful, comprehending and integrating victimization are ultimately solidly grounding and thereby liberating both for our patients and for ourselves.

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# *The Trauma Story: The Psychiatric Care of Refugee Survivors of Violence and Torture*

RICHARD F. MOLLIKA

## THE CLINIC'S HISTORY AND METHODS

During the year of the snake, the God of the Sun came to stay in my body. It made my body shaky all over—and I fainted. Upon awakening, I can remember as I opened my eyes that it was very dark. I then went to the rice fields to find someone to ask them what time it was. A voice shouted 10 o'clock. Suddenly, the owls began to cry and all the animals which represented death were howling all around me. I could also barely see a small group of people whispering to each other in the forest. I became so frightened that I tried to calm myself by praying to all the Gods and the angels in heaven to protect me from danger. I was so paralyzed with fear that I was unable to walk either backwards or forwards.

I came to settle in East Boston near the ocean. Now when I

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This chapter reflects the innovative clinical work of all members of the Indochinese Psychiatry Clinic. Special acknowledgments are due the clinics' other founding members—James Lavelle, LICSW, Binh Tu, and Ter Yang. Case 2 was prepared by IPC clinician Amy Utoft, R.N., M.S. The review of the outcome studies was assisted by Mary Harvey, Ph.D.



dream, I always see an American who dresses in black walking along the sea. One day when I was in my sponsor's house, I had this vision. This year, the Year of the Cow, I would like the American people to help me build a temple which will be located near the seashore. Since the Pol Pot soldiers killed my children, I am so depressed that all I can think about is just to build a temple—that is all. God appeared to me again the other day, and he told me to build a temple. Please help me make my dream come true. If not, I do not think I can live any more.

This plea for help was given to the author by an elderly Cambodian widow who had lost her husband and most of her extended family during the Khmer Rouge regime (1975–1979). It took many years before we could hear the requests and the stories of our Indochinese patients. Primo Levi, in his book *Se questo é un uomo* (*Survival in Auschwitz*) (Levi, 1986), describes the two most recurrent dreams experienced by himself and his fellow concentration camp survivors in Nazi Germany. One dream was about eating. The prisoners would dream about eating in their sleep—moving their empty mouths and grinding their teeth as imaginary food briefly healed their aching and hungry bellies. In the second dream, the prisoners had returned home and were sharing with their families their concentration camp experiences. But, no one would listen.

It is an intense pleasure, physical, inexpressible to be at home, among friendly people and to have so many things to recount; but I cannot help noticing that my listeners do not follow me. In fact, they are completely indifferent; they speak confidently of other things as if I were not there. My sister looks at me, gets up and goes away without a word—the grief is unbearable. (p. 60)

When we founded the Indochinese Psychiatry Clinic (IPC) (*Scientific American*, 1985), five years ago, we had no idea of the types of stories and experiences we would encounter over the next few years. In retrospect, this limited perspective was somewhat surprising since our Hmong colleague had led his tribe out of Laos under heavy gunfire (many people died) and the Vietnamese member of our group had suffered serious injuries in an explosion on a small South Vietnamese naval vessel. Initially we were afraid that we would not “understand” our refugee patients, and vice versa. We were especially afraid they would not return to the clinic—what did we have to offer them, anyway? On a Tuesday afternoon in January, the four of us met in the primary-



care clinic to see our first patient. Although we had had numerous refugee referrals from our medical colleagues over the previous few months, no one showed up to the psychiatry service. Eventually, we learned that Indochinese refugees are clever shoppers of health care and will tend to avoid "psychiatry" because of the stigmatization associated with mental illness as well as the fear that a psychiatric diagnosis will negatively affect their citizenship status. In response to these fears, we moved our clinic to the primary-care setting.

Our first patient was a Vietnamese woman whose daughter had been kidnapped at sea by Thai pirates. This young girl was still missing. Next were two Vietnamese women who had been referred to us because both had been raped at sea by Thai pirates and had recently attempted suicide by taking overdoses of pills. Our initial psychiatric evaluation included an extensive social history and traditional mental status examination. The two suicidal Vietnamese women were especially overwhelmed by the "brutal" force of our examination. Neither returned to the clinic after the first meeting. One of them was courteous enough to call us to tell us that we had made her feel worse than her original state prior to the meeting.

Our fourth patient was a Cambodian widow. After six months of treatment for a serious depression, she revealed to us that her parents had been disemboweled in front of her. She had been beaten on the head; then, she was thrown unconscious by the Pol Pot troops on the bodies of her relatives. She was left to die. Our traditional American psychiatric training had left us totally unprepared to deal with these tragedies. During the first year in our clinic, we were bewildered by "what to do?" Yet, many patients continued to flow into the clinic quiet and depressed.

The clinic atmosphere the first year was somber. It had the emotional atmosphere of a funeral. The morning following the Tuesday clinic, none of us could easily awaken from our labored sleep. Naively, we all accepted (and still accept) this phenomenon as part of our job. Little by little, like pebbles of sand poured into a pile on the beach, we began to listen to the stories of our patients' lives. Our clinic's academic goals also changed as we shifted our emphasis from our public service goals to caring for refugee survivors of violent and traumatic experiences. Finally, after the completion of our outcome study (which described our patients and their social and psychological responses to our efforts), we acknowledged that the majority of our patients had been tortured (Mollica, Wyshak, Coelho, & Lavelle, 1985b).

The psychiatric care of the survivors of mass violence and torture is



in its infancy. For example, little is known of the medical and psychological sequelae of human cruelty (Goldfeld, Mollica, Farenze, & Pesavento, unpublished). Logue, Evans, and Hansen (1981) review the limited general-research literature on the health effects of disasters (both natural and man-made). The work of Lifton (1967) on the aftermaths of Hiroshima and of Eltinger (1971) and Krystal (1968) on the concentration camp experience deserves special attention. Of course, each generation wants to make its own discoveries without being blinded by the observations of the past. Consequently, in order to confront the phenomena of our refugee patients without prejudice, we "bracketed" the phenomena. This phenomenological approach, which has been widely applied in Europe, allows the clinician to directly engage in experiencing the subjective experiences of his patients without introducing clinical biases that might obscure what actually exists.

Franco Basaglia and his colleagues recently applied this method in their reform of Italian psychiatry (Mollica, 1985). ("This process took the form of a stance that entailed 'bracketing' the objectifying and stigmatizing parameters that stifled the capacity to relate to the subjective experience of the Other" [Crepet and Pirella, 1985, p. 157]). For example, if it is generally believed by Western clinicians that "Asians primarily express depressive feelings as somatic complaints" or that all victims of mass violence have "survival guilt," the acceptance of these presuppositions must be suspended in order to confront the new phenomena. Of course, this approach might actually reaffirm the validity of these generalizations for refugee patients. In developing our understanding of our refugee patients and their treatment, we subsequently bracketed many commonly held conceptual systems such as "survivor guilt," "somatization," and "post-traumatic stress disorder." The bracketing of therapeutic approaches for our clinic's patients was less difficult because little is known of the most effective treatment of serious trauma including torture. Scurfield, in *Trauma and Its Wake* (1985), reviews the bewildering range of possibilities for treating post-traumatic symptoms. These include behavioral techniques, imaginal flooding and implosive therapy, systematic desensitization, hypnosis, abreaction, psychoanalysis, and so forth. Psychopharmacology has had an important role as well in the more recent treatment armamentarium for caring for survivors of trauma (Scurfield, 1985). In spite of many claims, few empirical studies exist that support the effectiveness of these various treatments including providing no treatment at all.

The few treatment outcome studies that exist need to be briefly described. Videka-Sherman (1982), in a well-designed study, evaluated



those coping factors which contributed best to parental adjustment to the death of a child. Her findings, based on the longitudinal study of bereaved parents, revealed that the most adaptive coping mechanisms were active and socially directed activities, including involvement in altruistic projects and reinvestment of interest in another person or meaningful activity. Denial of the traumatic event and its counterpart, preoccupation with the death, especially if persistent, were associated with unremitting depression. Her comparison of the impact of self-help groups on the outcome of her study's subjects suggested that the self-help groups contributed significantly to the altruistic behavior of its members. They might have also reduced the preoccupation of their members with the loss.

The outcome findings of Vail-Williams and colleagues (Vail-Williams, John, & Polak, 1976; Vail-Williams & Polak, 1979) on life crises following sudden death in families are both impressive and sobering. Their investigation reaffirmed the negative health effects of sudden death on family survivors. Yet, individuals who developed closer family relationships experienced the most favorable outcome. Unfortunately, they also found that crisis intervention did not significantly improve the situation. Their data revealed that short-term crisis intervention that utilized cathartic approaches had little or no impact on the post-adjustment of family survivors. In fact, the crisis service may have actually delayed or interfered with the natural healing that occurs within individual families.

Outcome research on the psychiatric care of more seriously disturbed trauma survivors is also limited. Lindy and his colleagues (Lindy, Green, Grace, & Titchener, 1983; 1986) revealed the effectiveness of psychotherapy in ameliorating the symptoms of individuals developing major psychiatric disorders following their rescue from the Beverly Hills Supper Club Fire (1977). Our recent outcome study revealed major psychological and social improvement in 52 Indochinese patients (many who had been tortured) over six months of treatment (Mollica et al., 1985b).

Our successful but limited treatment results proved encouraging to the IPC staff (Mollica et al., 1985b). In our clinic, lack of guidance on the proper treatment of traumatized and tortured refugee patients had led to mixtures of excitement and despair: excitement in the joint discovery by both patients and staff of effective treatment approaches, e.g., with the Cambodian women's group (Mollica, Lavelle, & Khuon, 1985a); despair in the face of the futility and frustration at our lack of therapeutic power for many refugee patients. The discussion of the treatment approach that follows, therefore, is a summary of the ex-



perience of a group of clinicians who have modestly confronted the psychological problems of our refugee patients over the past five years.

## HOPELESSNESS AND DESPAIR

As our own experience deepened, a natural sense of humor and affection began to develop between ourselves and our patients. The funeral atmosphere was finally broken—not only after we witnessed that some of our patients had improved, but also after the staff recognized that many of our patients were infecting us with their hopelessness. During the first year, the major task of treatment was to cope with the hopelessness of our patients. We learned that their hopeless feelings were extremely contagious. Initially, we perceived the total lack of programmatic support for our efforts from state and federal government as the cause of our despondency. Many of our patients were homeless; often patients could not afford their medications. Signs of the current disintegration of public care for the mentally ill had become commonplace in our state (Mollica, 1983). Yet, our service never lacked the political motivation to care for those who had been relegated by society to the "dustbin." (Paradoxically, publicly revealing the tragedies of our patients' lives to politicians and policy planners often brought greater social neglect.) Yet, it is still our belief that the major feelings of *hopelessness* were spread throughout the service by the *trauma story*. Most of the stories of our patients were stories of hopelessness and despair. These stories have great power over the patients and can easily overwhelm the untrained listener.

## THE PSYCHIATRIC EXAMINATION

### *The Treatment Setting*

Refugee patients will seek health care consistent with their cultural expectation and traditional health-seeking behavior, as well as their trauma history. Indochinese patients are generally unfamiliar with Western psychiatric and mental health practitioners. In general, physical symptoms are the appropriate domain of medical physicians and native healers; emotional symptoms are most appropriately brought to family, friends, and religious leaders. Furthermore, many refugees (especially those most familiar with Western psychiatry) associate shame and



humiliation with their perceived need to seek help for a "broken mind or spirit." These attitudes are exacerbated by migration policies in the refugee camps which prevent refugees who have received psychiatric diagnoses in the camps from being resettled. Furthermore, major psychiatric disorders, if known by the U.S. Immigration Service, will interfere with the ability of refugees to achieve citizenship status. In response to these problems, IPC successfully established its treatment offices in the primary-care setting. Confidentiality is actively discussed with each patient.

The Danish investigators who created the first torture center in Europe initially stressed the need to avoid, in every examination and treatment setting, situations that might remind the survivors of torture of their torture experience (Genefke, 1984).

It is necessary, therefore, that the person in touch with the victim possess knowledge about the torture to which the victim has been exposed in order to avoid situations that may induce fear. Induction of pain during [physical] examination must be kept at a low and tolerable level. If the patient for instance has undergone electrical torture special precautions should be taken if doing EEG or ECT. For victims who have been soaked in their own blood or have seen friends bleeding, the drawing of a blood sample can be traumatizing. . . . Great caution should also be taken in regard to exploratory procedures . . . if the victim has been tortured by having, e.g., bottles, batons or water forced into [the] vagina or rectum or has been sexually abused. (p. 2)

Care must be taken, however, not to generalize from the torture/trauma literature to individual clinical settings. For example, a Cambodian community in Boston will seek its medical and psychiatric care in a culturally consistent manner and will have different expectations of this care than Chilean exiles in Europe or torture survivors seeking attention in their homeland. Sensitivity to community norms consequently demands considerable personal contact of the staff with the refugee community. The general acceptance of the clinic's activities by the community is also crucial to the success of the clinic's activities.

### *The Psychiatric Interview*

The psychiatric interview should consist of "guided" open-ended questions because many traumatized refugee patients are easily over-



whelmed by the intensity of their emotional response to the examiner's questions. Despite such an approach, a semistructured comprehensive mental status examination may still yield little information because refugees can be especially shy, reticent, and unable to articulate their feelings. To overcome this problem, we developed and validated a screening instrument, the Indochinese language version of the Hopkins Symptom Checklist-25 (HSCL-25) (Mollica, Wyshak, de Marneffe, et al., 1985c). The HSCL-25 uses four categories ("not at all," "a little," "quite a bit," "extremely") to respond to such questions as "suddenly scared for no reason?" "feeling hopeless about the future?" etc. The Southeast Asian refugee seems better able to respond to psychological questions that appear in the form of a medical test, such as the HSCL-25, rather than questions asked of them during a personal interview. The HSCL-25 allows the patients to "put words" around their feelings of anxiety and depression without reliving the trauma experience through a personal interview in which the trauma experience is described. The HSCL-25 is best introduced into the psychiatric interview during the first session because it can help guide the evaluator toward additional questions.

### *Evaluation and Diagnosis*

If mental health providers are to treat refugee patients, they must be able to diagnose depression (major affective disorder), post-traumatic stress disorder, organic brain syndromes, and schizophrenia. Psychiatric diagnosis is difficult, not only because of cultural and linguistic barriers, but also because highly traumatized patients will avoid discussing their traumatic experiences and trauma-related symptoms. Getting refugee patients to provide details about their lives is often initially extremely difficult. On the other hand, it is not uncommon for refugee patients to begin their first evaluation interview with an extremely moving story (Cienfuegos & Monelli, 1983). In fact, it is rare for a refugee patient not to reveal "psychologically" minded details at some time during the course of the evaluation.

Special attention must be given to asking the Indochinese patient about the symptoms of post-traumatic stress disorder (Kolb, 1986). The clinician should recognize that the refugee patient may not freely provide these symptoms and, in fact, may initially deny them. Frequently, a history of nightmares and bad dreams provides the only clinical evidence that a patient may have experienced serious trauma that he/she is not emotionally ready to disclose (Kramer, Schoen, & Kinney, 1984). It is



not uncommon for the trauma event to be revealed in the dream (Van der Kolk, Blitz, Burr, et al., 1984). It is not known, however, whether or not refugee patients meet all of the DSM-III criteria for PTSD, since many of the latter may be culture-bound symptoms, e.g., "survival guilt" (Horowitz, 1986).

### *The Indochinese Paraprofessional*

Little cross-cultural literature exists on the relationship between patient, Western professional, and bilingual interpreter (Borus, Anastasi, Casoni, et al., 1979). Furthermore, there have been few discussions of what can be learned by Western professionals from Southeast Asian paraprofessionals within this unique triad. This lack of appreciation of the cultural value of the bilingual interpreter is partly due to the hierarchical relationship that is assumed by Western health practitioners. Even within the most culturally sensitive medical settings, the "interpreter" is viewed simply as an extension of the diagnostic process. This approach, however, is seriously flawed. Indochinese paraprofessionals are not just "interpreters" or "translators"; they are specialized mental health clinicians who must move conceptually between Western models of disease and treatment and the unique medical and psychiatric world view of their own culture. Unless an Indochinese clinician is professionally trained and supervised, he or she will not know how to adequately convey subtle medical and cultural meanings between patient and physician. The "interpreter" model is so frequently abused by physicians and hospitals that most Indochinese clinicians resent being treated as the physician's personal mouthpiece, i.e., as if they were an inanimate medical instrument.

### *Duration and Intensity of Treatment*

Highly traumatized refugee patients initially can only tolerate limited discussions of their lives. Scarce resources limit the ability of most staff to provide each patient with a standard one-hour therapy session. Using a brief contact model, therapy must provide continuous weekly support of the patient through which even the most symptomatic refugee patient can be safely managed as these patients develop less symptoms and a more hopeful attitude toward their lives. Most important, IPC's slogan, "a little, a lot, over a long period of time," expresses the need for the staff to maintain a long-term commitment to the refugee patient. These patients need to be told by the staff that they can be seen indefinitely



until their situation improves. This verbal commitment of long-term treatment support by staff to the patient is especially helpful to those refugees who are socially isolated and feel hopeless about their ability to recover from the atrocities they have experienced.

### *Psychopharmacology*

Psychotropic drugs are widely used in the treatment of Indochinese refugee patients. Indochinese patients expect physicians to prescribe medications for their symptoms. Most significantly, however, the severity of psychiatric disorders that generally present to a refugee clinic demands that the treatment team be able to rapidly ameliorate the extreme psychological distress of their patients.

There is little research on transcultural psychopharmacology (Chien & Katz, 1979). Early surveys found that dosages of medications can vary as much as 10 times from one country to another. Research thus far shows two basic facts about the use of neuroleptics in Asians. Asians have been reported to be more likely to develop acute extrapyramidal side effects than white patients on comparable doses of haloperidol. Second, Asians appear to require lower doses of these drugs to achieve therapeutic effect. It is, therefore, a consensus of clinical observations that lower doses of most psychiatric medications can be used in Asians without compromising their therapeutic effect.

### THE TRAUMA STORY: THE CENTERPIECE OF THERAPY

Our experience in treating over 800 Indochinese patients has provided us considerable insight and experience with the psychological realities of trauma and torture. However, each stage of the development of our treatment (aided by our phenomenological method) has continued to reveal retrospectively the inadequacies of the previous stages. The psychotherapy of the torture survivor is in its infancy. As previously indicated, except for a few outcome studies, there is almost a total lack of literature in this area. The observations to be made in this section are exploratory, the conclusions only hypothetical. Limited cultural knowledge about our patients' lives (e.g., the Buddhist world view), the therapist's distress in reviewing the trauma story, and each patient's own reluctance and emotional inability to share his or her subjective



reality create considerable barriers to devising an adequate clinical (and human) response. Freud (1984) highlighted these difficulties when he warned:

No matter how much we may shrink with horror from certain situations—of a galley-slave in antiquity, of a peasant during the Thirty Years' War, of a victim of the Holy Inquisition, of a Jew awaiting a pogrom—it is nevertheless impossible for us to feel our way into such people—to divine the changes which original obtuseness of mind, a gradual stupefying process, the cessation of expectations, and cruder or more refined methods of narcotization have produced upon their receptivity to sensations of pleasure and unpleasure. Moreover, in the case of the most extreme possibility of suffering, special mental protective devices are brought into operation. (p. 89)

Yet, no matter how the therapist conceives of his theoretical orientation, the *trauma story* emerges as the centerpiece of treatment. Every refugee patient has at least one traumatic experience that figures prominently as an essential aspect of his life history. The trauma story is often a hidden secret (such as a rape trauma) being desperately concealed from others; the trauma story is usually reviewed nightly in the patient's nightmares (one Laotian woman described her nightmares as a living hell); the trauma story is the imprint of history on the patient's memory—a personal narrative in the mind that is retold daily as it is searched for new meanings and clues. For example, most Cambodian patients state, if asked to give their past history, "On April 20, 1975, the Pol Pot troops . . ." This beginning is an acknowledgment by the patients of a life experience that gave birth to their new lives.

#### THE DIFFERENT CULTURAL MEANINGS OF TRAUMA

The Western clinician cannot begin to understand the trauma story until he has become acquainted with the unique cultural meanings of the terms "trauma" and "torture" in the different Indochinese cultures. The subjective meaning of trauma and torture in the life of any individual is articulated through language and the historical and culturally constructed traditions and customs that make sense of these experiences.



An individual experiences traumatic events within his own unique culture universe. For example, examination of the definitions of the word torture in Cambodian and English reveals striking differences. The English derivation of the term is from the Latin roots *tortum* and *torquere* (Table 1). Torture in the Western world has consistently been associated with the use of physical pain to force testimony. It is still frequently used for this reason in political situations. The Cambodian term, in contrast, is associated with the Buddhist concept of Karma (Table 2). Cambodian patients who have been tortured generally feel they are somehow responsible for their suffering because of their Karma. The implications of this knowledge for treating Indochinese patients are far-reaching. The trauma story, therefore, is not only a story of violence, but also a description of that society's responses to these events. The subjects, in fact, only begin to enter the trauma story when they can reveal the psychological impact of these traumatic events on their lives.

TABLE 1  
Western Definition of the Term Torture

- 
- Derives from the Latin word *tortum*—i.e., a tort or wrongful act—and the Latin word *torquere*—i.e., to cause to turn, to twist, hence to physically torture
1. The infliction of excruciating pain or suffering (of body or mind) as practiced by cruel tyrants, savages, brigands, etc., from a delight in watching the agony of the victim, in hatred or revenge, or as a means of extortion
  2. Inflicted by a judicial or quasijudicial authority, for the purpose of forcing an accused or suspected person to confess or an unwilling witness to give evidence or information
  3. Severe pressure; violent persuasion or wresting
- 

TABLE 2  
Cambodian Definition of the Term Torture  
(ត្រូវ ទុក្ខ កាម; *tieru na kam*)

- 
- Derives from the Sanskrit/Pali words *daruna* and *kama*—i.e., savagery, cruelty, barbarism
1. (ត្រូវ ទុក្ខ; *tierun*)  
cruel, ferocious, savage
  2. (កាម កាម្ម; *kam; kammea; karma*)  
Action, deed, act, activity; a work; calamity; fate; Karma; an action or thoughts (often of an evil nature) in a prior existence that produce effects in a subsequent existence
-



THE PSYCHOLOGICAL MEANING OF TRAUMA  
AND TORTURE

The psychological dimensions of trauma and torture appear to have two universal dimensions: (1) loss of control, and (2) "losing the world." We use the term "losing the world" because it seems to be the most accurate description of the total subjective loss of one's reality. Krystal (1978), in his excellent description of the "psychology of trauma," distinguishes between "partial" trauma and "catastrophic trauma." He states, "The psychic experience of 'catastrophic trauma' consists of a numbing of self-reflective functions, followed by a paralysis of all cognitive and self-preserving mental functions" (p. 113). Catastrophic trauma conforms closely to losing the world. The major psychological aspects of losing the world are summarized in Table 3.

Once an individual has lost the world, he can become totally trapped in his trauma story. In fact, all generally held social and cultural beliefs are replaced by the only reality he has been forced to know—the trauma story. In fact, many of our patients "become" their trauma story. Our refugee patients who have had this experience are seriously depressed. They are plagued by traumatic symptoms—nightmares, insomnia, and waking memories. They will often describe these symptoms as causing them to be in a living hell. These patients live in a world of traumatic images and memories in which nothing exists for them except the trauma story. Their psychological reality is both full and empty. They are "full" of the past; they are "empty" of new ideas and life experiences. Social isolation and withdrawal are usually present. As Primo Levi (1986) has stated, they are individuals who lie on the bottom.

Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short, of everything he possesses: he will be a hollow man, reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often loses himself. He will be a man whose life or death can be lightly decided with no sense of human affinity, in the

TABLE 3  
Losing the World

- 
- |  |
|--|
| 1. Everything is taken away; nothing is given back                                 |
| 2. Total loss of control—recognizing that one is only part of someone else's story |
| 3. Total lack of empathy, understanding, love, and affection shown toward you      |
-



most fortunate of cases, on the basis of a pure judgment of utility. It is in this way that one can understand the double sense of the term "extermination camp", and it is now clear what we seek to express with the phrase: "to lie on the bottom." (p. 27)

Lying on the bottom means to be abandoned by both friends and relatives. Social isolation characterizes the social state of IPC's most traumatized patients. Our staff is often the only social contact these patients have. Yet, maintaining this contact is difficult because of the general lack of trust of any individual who lives in a world that has generated so much cruelty and suffering. The patient is silent. The trauma story becomes an inner personal obsession. This long-term silence is especially true after rape.

### THREE TRAUMA STORIES

The following trauma stories have unique meaning to each individual's life history. Case 1 describes a Laotian woman who eventually experienced significant relief from her suffering after revealing her "secret." Case 2 highlights a young woman's struggle to escape from the entanglement of her sexual torture. Case 3 depicts a man who has totally lost his world and is entrapped within his trauma story.

#### *Case No. 1: The "Silent Sufferer": Revealing the Trauma Story*

S.T. is a 45-year-old Laotian widow with a negative past medical and psychiatric history. S.T. was referred to IPC by her primary-care physician since a medical diagnosis could not be found for her chronic somatic complaints.

S.T. came from a middle-class Laotian background. After the fall of Laos in 1975, she and her husband were sent to Communist reeducation camps. Her husband was eventually executed when he was discovered to have worked for the previous government. S.T. initially presented to IPC with the symptoms of a major depression. She denied having any traumatic symptoms such as nightmares or upsetting memories. After three years of intensive treatment (including many different trials of medications), S.T.'s depression remained severe and unremitting. Finally, after S.T. was offered a new therapeutic approach, she stated, "No medication can relieve my suffering."



S.T. subsequently revealed to her therapist that she had a "secret" trauma story. Nobody knew about what had happened to her in Laos under the Communists. S.T. had been "raped" by a communist soldier who had been a close friend to her during her childhood. She could not believe that this man, whom she had once liked very much, could have done this to her. During her escape in 1979, she was captured by soldiers and was repeatedly raped by them while her small children watched.

Since these events, S.T. has silently suffered with the shame of her secret trauma. She finally was able to admit that she suffered daily from recurrent nightmares and memories in which she relived these events. Her daily life was a "living hell." Once S.T. shared her story with her therapist (slowly over a three-month period), she began to experience some reduction in symptoms and a dramatic improvement in her feelings of hopelessness and shame.

*Case No. 2: "Escaping the Trauma Story"*

V.K. is a teenage Vietnamese woman who was referred to IPC by the primary-care clinic after she witnessed a "holdup" in a supermarket in which a policeman was shot. The incident triggered a barrage of psychiatric symptoms, including dissociative episodes in which she saw "visions" and heard threatening voices from the war. Prior to this incident, she had presented frequently to the primary-care clinic with various somatic complaints, including reports of having "seizures." All medical investigations were negative.

V.K. arrived in America when she was 15 years old. She had spent the previous 5 years in Communist work camps. In these camps, she was a victim of extreme mental, physical, and sexual torture. She reports multiple beatings, being hung by her ankles from a tree for three days, and spending months in solitary confinement in an underground cell. She was repeatedly raped by the Communist soldiers when she was 11 or 12 years old.

V.K. was assigned to an IPC American professional for psychotherapy because of her fluency in English. Initially, she was eager to tell her trauma story to her therapist. She requested that her therapist ask her about her work camp experiences. For months, the therapy consisted of a repetitive retelling of the traumatic events of the trauma experience. Her daily life during these months was consumed by nightmares and daily memories of the trauma. Her trauma story was told over and



over again (often using prepared notes). After one year of therapy, this cycle was eventually broken, and she became able to discuss spontaneously other aspects of her life, both past and present.

*Case No. 3: "Trapped" in the "Trauma Story"*

R.H. is a 50-year-old, married Cambodian man who was referred to IPC by his sponsor after arriving in America because of a serious depression. R.H. was a Buddhist monk prior to the Khmer Rouge takeover of Cambodia in 1975. After the fall of Phnom Penh, he escaped from the temple and was eventually captured by Communist soldiers and placed in a work camp. Eventually, because of his Vietnamese background (he was Cambodian born and raised in Vietnam), he was tortured. His entire family (47 members) were subsequently executed. He was the only living survivor. In 1979, R.H. escaped to Thailand. He remained asymptomatic until he saw one of the men he believed had helped murder his family. He subsequently developed an uncontrollable "murderous" rage, including nightmares and overwhelming memories of his and his family's torture. In a total state of emotional despair, he asked a friend to paint a mural depicting the tragedy of his family.

R.H. is remarried and lives with his new wife and two children. R.H. can do absolutely nothing except discuss his mural, which is six feet by six feet and hangs over his bed. Whenever he leaves his home, he folds up his mural and takes it with him. (This painting is a gruesome depiction of the torture of each family member.) After three years of extensive involvement with IPC's staff, R.H. will rarely discuss anything but his mural. He considers it a "shrine" to his family. He will show it to anyone who is interested, including American strangers. His obsession with his trauma story has crowded out of his life all other experiences and activities.

**TELLING THE STORY IS THE FIRST STEP IN THE  
CONSTRUCTION OF A NEW STORY**

Eventually patients will share their life stories with their clinicians, but it may take years before this occurs. This is the primary goal and method of our treatment. The importance of storytelling cannot be underestimated in the traditional life of our patients, as well as for its therapeutic effect. "No-one, Pascal once said, dies so poor that he does



not leave something behind" (Benjamin, 1969). Surely, this is also true of our patients' lives. The therapist becomes the heir to their tragic legends; initially, they are often the sole heir. Once the patient is ready to tell the trauma story, the narrative begins to give shape to many new possibilities. The patient's previous interpretation of his story as a hopeless loss of control is diminished. The untold trauma story keeps him stuck in the past in a world that defies all cultural meaning, interpretation, and, most important, social manipulation (e.g., Case 1). The storytelling begins to give flexibility to what was rigid and fixed in time (e.g., Case 2). The past which was fixed in the present releases the present to new experiences. The past also becomes a future, a future of the past and present. Of course, the telling of the story makes room for the disturbing thought that the suffering of the past can and will extend into the future. Patients are often afraid to tell their stories (preferring to remain in the past) because they are afraid to open up their lives to new catastrophes.

The psychotherapist is often bewildered by the exceptional individual who repeats his trauma story unremittingly. Since the therapist is so unsuspecting (and often so appreciative) of such open revelations, he can easily become entangled in these stories. The therapist who treated the Vietnamese teenager (Case 2) had to listen cautiously for over a year before she could aid this young girl in understanding her experience. In contrast, the former Buddhist monk (Case 3) has succeeded in overwhelming all his potential supporters with the magnitude of his suffering.

The situations described in the clinical cases, i.e., secrecy and repetitive storytelling, reveal what might be considered trauma stories in their untransformed state. They are in fact a "prenarrative" because as stories they have no development, do not progress in time sequence, and fail to actively reveal the storyteller's interpretation of the traumatic events. These untold or repetitively recited stories, however, are not to be dismissed. They are the initial introductions to the new story which will emerge in the therapy and will liberate the patient from the past. Dealing with the prenarrative stage is difficult for the therapist. The psychotherapist can easily feel frustrated or rejected by the secret that is never shared or feel awed or insignificant in face of the magnitude of the repetitive story. In addition, the patients who have become the trauma story (e.g., Case 3) will attempt to overwhelm, horrify, and amaze the psychotherapist with the tragedy of their lives.

Listening to the small personal details of the refugee's life that lie within the trauma story is also difficult. Yet these details must be



retrieved for the patient to develop a human sense of perspective. Dissatisfaction with a spouse's eating habits can be much more significant to a refugee woman than repeating again her account of the trauma experience. The psychotherapist is also generally afraid to allow the patient's affect to develop as the new story emerges. This affect can often be explosive anger—toward the torturer, the patient's own country, America, and the therapist. IPC clinicians are especially afraid to portray themselves to their refugee patients as anything but warm, generous, and interested. This clearly reflects our attempt to control the anger we suspect lies trapped within the trauma story.

### THE NEW STORY

The new story that emerges is no longer a story about powerlessness—about losing the world and being totally dominated by someone else's reality. The Danes, in their psychotherapy of torture victims (Genefke, 1984), emphasize the strength of their patients and explain to them the goals of torture—"to break down and distort the person's personality in order to induce in the victim a permanent feeling of being a different person than before torture which consequently creates great anxiety" (p. 9). Psychologists working in Chile with torture survivors use "testimony" to help their patients cope with their brutal experiences (Cienfuegos & Monelli, 1983). "The experience narrated through the testimony includes fragmented chronological and affective sequences that are then integrated in the written transcript of the recording. It is through this whole picture that the patient can identify, understand and integrate the meaning of their political commitment and suffering" (p. 50).

The new story is no longer about shame and humiliation—it becomes a story about human dignity and virtue. The new story is no longer about being a victim of one's own society—it becomes a story about human prejudices and the weaknesses of the so-called human civilizations in which we live. Through their storytelling refugee patients regain the world they have lost. They are no longer the trauma story, but become again the interpreters and storytellers of the past, present, and future lives they are now living. Our clinicians attempt to help our patients bridge this gap between the trauma story of helplessness and despair and the new story of survival and recovery. Storytelling is intimate and is shared between people—it binds the storyteller and the listener together. The bridging process can help patients regain their new world by establishing a more realistic assessment of their present



reality—a reality that can be affectionately shared with their families, friends, and community.

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## SECTION IV

# The Crime Victims' Movement and Support Services for Victims

This final section is authored by Marlene A. Young, a remarkable advocate for victims, with advanced degrees in both political science and law. Since 1981, she has been Executive Director of the National Organization for Victim Assistance. Earlier, she served the organization as a founding board member and as board president. Dr. Young has published widely in the fields of criminal justice, victimology, and gerontology. Her theoretical framework for understanding the concepts of victimization and justice has received international recognition. In the following two chapters, her discussion of self-help and advocacy for and by victims places the national movement in a historical context. This is significant information for those therapists who are currently entering the field of victim services. Activities at the state and local level often replicate the history of the national movement, bringing together professionals from the fields of mental health and criminal justice, forging alliances among consumers and providers, reconciling differences between grass-roots organizations and licensed clinicians.

An excellent example of local progress in advancing rights and services for victims, based on models provided by Marlene Young and NOVA, is the Crime Victim's Rights Act of 1985 (Michigan Public Act 87,



Enrolled House Bill No. 4009). Rep. William Van Regenmorter, member of the Michigan House Judiciary Committee, received a national award for his authorship of the act. In a personal correspondence he explains the impact of Michigan's Crime Victim's Rights Act:

The Act provides comprehensive legally mandated rights, incorporating several fundamental components: notification; information; participation; protection; and restitution.

Notification begins virtually at the time of the crime with a Miranda-like alert to the victim, listing basic rights and where to obtain more information. Following that notice, within seven days of the arraignment, the prosecutor must provide a detailed catalogue of all legal rights under the act. Later notices include court schedules, conviction and sentence details, impact statement rights and requirements, escapes, transfers to the community or nonsecure facilities, and parole hearings.

During interviews while developing the Act, the most frequent victim complaints about the criminal justice system included the phrase "We were ignored." Under the act, the victim may elect the legal right to participate in specific procedures throughout the process. There is a right to be present during the entire trial, rather than being sequestered, as had previously been routine. Consultation with the prosecutor about plea bargaining and trial strategy offers participation recourse for the victim. He or she may initiate procedures for confidentiality of victim court records and bond revocation when apprehensive about threats or intimidation. The victim may address the judge and/or provide information to the presentence investigator for summary or verbatim inclusion in the presentence report. Such statements may include details of physical, psychological, emotional, or financial harm as well as recommendations for sentence, restitution, and compensation. When the defendant is eligible for parole, the victim may address the parole board before a decision is made.

While this entire law represents protection for the victim, some very specific protective mechanisms are spelled out. Most defendants are released on bond before trial, but the victim is provided ways of determining if that is the case and a method to initiate bond revocation procedures when threatened. When apprehensive about threats of intimidation, victim's address, place of employment, etc., can be confidential, and the court is to provide waiting areas separate from the defendant or defense witnesses. Employers are required to protect victims from discipline when they miss work for required court appearances. Victims of child abuse and criminal sexual conduct may initiate procedures for a speedy trial.



and the impact statements can provide the judge with protection mechanisms to be incorporated in the sentence. If the defendant is incarcerated, the victim will be notified immediately of an escape or transfer from a secure to a nonsecure facility, or of placement into the community. Of course the victim can inform the parole board of the need for protection at that hearing.

The restitution requirements under the Act are extensive and include: return or restoration of property; cost of physical or psychological care; repayment of lost income and funeral expenses. The judge may assign the defendant to perform services in lieu of money. Restitution enforcement is enhanced by providing that it can be collected like a civil judgment and is a condition of probation or parole.

Thus, the current cycle of rights and services for victims of violence is complete. Grass-roots efforts to ameliorate the emotional impact of criminal victimization have grown into a national victims' rights movement. National events, in turn, promote state laws that encourage services for victims and recognize victims' rights. And all of this occurs in the historic, international context of the women's movement, the aftermath of the Vietnam War, and political terrorism. We learn, slowly and painfully, that a civilized society can and must address the trauma borne by its victims of violence.







# 15

## *The Crime Victims' Movement*

MARLENE A. YOUNG

Crime victims today stand a better chance of recovering from the psychological wounds of victimization than did their counterparts of 5 or 10 years ago. There are three reasons for this:

First, the common sequel of emotional responses to crime and other traumatic events has now been well articulated, and the basic elements of those responses appear to hold up even as important variations, depending on the nature of the trauma, are also being articulated.

Second, flowing directly from the understanding of post-traumatic stress and crisis are a set of tools to aid in the diagnosis, intervention, and treatment of the distress precipitated by crime and other traumas.

Third—and most important from the victim's perspective—a network of service programs, most of them helping particular classes of crime victims, has come into being and is now growing rapidly across the United States.

The first two developments, involving the etiology and treatment of a recognizable disability, demonstrate a familiar interplay between mental health researchers and clinicians. But the third development, the emergence of a victims' movement, has been created by people who for the most part have no mental health degrees and whose reform efforts, in fact, predated the involvement of most of the mental health professionals now in the field.

This chapter will examine that movement. It will review its history, including its grass-roots origins and self-help characteristics. It will describe the current agenda of the movement, including its passion for



jurisprudential reforms that are substantially motivated out of a desire to aid in the victim's emotional recovery. And it will explore the future of the movement, including its relations with friends, allies, and teachers in the mental health professions.

The crime victims' movement in the United States has been in existence for approximately 15 years. Its history conveniently divides into five-year phases.

To understand the first phase, 1972-1976, when the first service programs were established, it is worth contemplating the forces of the preceding decade that gave rise to the new services.

Perhaps the most significant of these forces was the extraordinary rise in the rate of crime during the 1960s, which led to a sense of public outrage and the formation of a series of presidential study groups—the "crime," "riot," and "violence" commissions—of which the first was probably the most influential. It developed the first victimization surveys, and its recommendations helped to create the Law Enforcement Assistance Administration (LEAA), an agency that would fund new victim service programs in the 1970s.

Also helping to set the stage for what would follow were two other government initiatives. One was the "discovery" of child abuse and a concomitant involvement of government in attempting to curb it. The second was the invention of state-funded victim compensation schemes by a British penal reformer, an idea adopted by a number of states after California's landmark legislation in 1965.

The most fervent influence came from the modern women's movement, which from its outset viewed rape as an outrageous symbol of woman's subjugation by man. Women's groups threw their energies into starting crisis centers to deal with the victims of such brutality. Of the first three victim assistance programs established in the country—all in 1972—two were rape crisis centers, and such centers would in time set the model of crisis response to all crime victims.

By 1974, the women's movement began to remove the shroud of secrecy hiding another symbol of male domination—spouse abuse—by opening the first battered-women's shelters.

Looking backward, one can identify one characteristic of the early rape crisis centers and battered-women's shelters that was not often revealed at the time, but which probably contributed to the ardent persistence of these programs—many of their leaders and line volunteers (who were most of the programs' staff) were themselves former victims of sexual assault and domestic violence.

Given the culture of the time, it was little wonder that the former



victims often kept their histories with crime private. After all, the validity of their basic message about their *clients* was being denied, and some calculated that if they advocated for change as victims, too, their message would receive an even worse reception.

It would be years before victims would be accorded a sense of dignity and validity such that they spoke out in great numbers as victims, and as survivors. Still, the victims' movement always had aspects of self-help and mutual support about it, and nowadays, activists in the movement subscribe to those feelings with a sense of pride.

Another certainty about the early years is that the founders of the sexual-assault and domestic-violence victims' programs led a grass-roots assault not only on the criminal violence that was at issue, but also on the criminal justice system that at times seemed to ignore, if not condone, the violence.

It would be an understatement to say that most leaders of the criminal justice system did not welcome the criticism of the women's groups. Nevertheless, some individuals within the system recognized that the maltreatment of victims and witnesses caused prosecutions to fail under the rubric of "witness noncooperation." That prompted the infusion of federal funds into the field, notably into prosecutors' "victim/witness" units, of which the first 10 were started with LEAA funding in 1974.

Others in government looked beyond the criminal justice payoffs, or at least concluded that a modicum of late-arriving aid, offered to just that one victim in 20 whose case resulted in a prosecution, would not only be inequitable but might be too little too late to win full cooperation from victims. Hence, then-Prosecuting Attorney (now U.S. Senator) Dennis DiConcini, in Pima County, Arizona, set up a program not only to help witnesses but also to respond quickly to victims, sometimes at the scene of a crime, whether or not there would be an arrest and prosecution.

A National Institute of Justice evaluation of victim services in New York resulted in the formation of a comprehensive, nonprofit victim service agency outside of the government structure, though intimately involved with the prosecutors' offices in several boroughs.

The victim/witness program begun in the Palm Beach County State Attorney's office moved to county government so that it could serve all those in need. Interestingly, some years after that program was relocated, the State Attorney reopened an in-house victim/witness program as a complement, not a competitor, to the county's crisis intervention program.

Other criminal justice agencies began to join in during the mid-1970s.



James Rowland, Chief Probation Officer in Fresno County, California, argued that a local probation department was the most appropriate place for victim assistance since its staff, unlike any other justice agency's, was already trained in counseling.

The Indianapolis Police Department became one of the first law enforcement agencies to host its own crisis intervention program.

All of these early programs were geographically isolated from each other. But thanks to the national women's network, the interest at LEAA's headquarters, and the desire among the new practitioners to learn from one another, word of the new services got around, and new adherents to the idea were emboldened to try it in their communities.

While new services were being started in the period 1972-1976, researchers were also beginning to explore how victimization may have hidden consequences for both the individual and society as a whole. Victimization surveys conducted by the U.S. Census Bureau provided a wealth of data on the extent of crime in the United States, and early research focusing on rape (Burgess & Holmstrom, 1974, 1978), domestic violence (Bard, 1970; Bard et al., 1975; Bard & Zacker, 1971; Walker, 1979), and elderly victims (Ernst et al., 1976; Young, 1976) began to give depth to the nascent reform effort.

While many of the preliminary research findings were modified over the years, none proved more durable or more influential than the identification of a "rape trauma syndrome" by Ann Burgess and her colleagues. Not only did this careful outgrowth of research and treatment produce specific intervention strategies with victims of sexual assault, it was also the precursor of other important syntheses—notably, the "Vietnam veteran's syndrome" and the "battered-woman's syndrome"—all of which contributed to the subsequent identification of the larger synthesis, the post-traumatic stress disorder.

Manifestly, the forces behind the new movement were diverse. Yet there was a common sense of mission among the researchers, volunteers, criminal justice innovators, and crisis workers. All shared a sense that the way victims were customarily treated in the aftermath of crime was deplorable. And in their search for solutions to the problems they kept uncovering, they began to look beyond their own jurisdiction for answers.

The resulting communication led to the convening of an LEAA-sponsored, national meeting of some 36 individuals in Fort Lauderdale, Florida, in 1974, then to the founding of the National Organization for Victim Assistance (NOVA) in 1975 (mostly through correspondence among its initial board members), and then to a far larger national conference on victim assistance in 1976. That Fresno conference, though



remembered as the "second" in what became a series of annual conferences, was probably the catalytic moment when the early pioneers resolved to join together for the long haul, and to see their mission through to completion, if possible.

It seemed, at the end of 1976, that the victims' advocates were well on their way to launching a victims' movement. However, the next five years were as notable for the outbreaks of dissension from within and enforced instability from outside as they were for the progress that was being made.

A major contributor to the instability was the ebb and flow of federal funding. Few victim service programs were well enough established to attract local funding sources, and much of the early development depended on federal seed money grants. But by 1976, federal interest had shifted to other concerns, and funding diminished.

Then, in late 1978, a new federal initiative for victim and witness programs was announced. For the next year and a half, local programs were nurtured into being, and development grants were awarded to a number of state "networks" (typically a small office seeking to form a coalition of local service programs). But almost as soon as the new flow of funds began to make a difference, the funding was halted one more time. The congressional decision to disband LEAA in 1979 left many programs defunct before they had really had any effect in their states.

Vagaries in funding only compounded divisions in the movement. A typical scenario was a competition for scarce money between a local rape crisis center, the prosecutor's victim/witness assistance program, and a domestic violence shelter. Charges and countercharges amid all of the programs about the value and integrity of each were sometimes so unpleasant as to cause all the services to lose respect—and funding.

Often there were more philosophical disagreements, typically over the relative worth of grass-roots organizations versus those housed in the criminal justice system. There being no common agreement that the services both types of programs offered were valuable to their common clients, and facing common budget cuts, the programs often fell into arguments that were removed from the needs and interests of clients.

Thus, independent of the quality of services a program might provide, it might be faulted for not working overtime to combat sexism in the community—or, conversely, for doing just that—or for working too hard to seek the convictions of offenders—or, conversely, for not working at all toward achieving that goal.



In short, the diversity of the movement was a phenomenon not highly prized by many of its members. That divisiveness was publicly illustrated at NOVA's 1978 national conference in Minneapolis. Sexual-assault program representatives caucused and voted to establish a separate national organization, the National Coalition Against Sexual Assault (NCASA).

While both organizations have gone on to make necessary and worthy contributions to the victims' movement, and while many victim advocates are members of both, the heat of the moment left a legacy of animosity that has hampered progress in some areas. Energies were diverted not only to interorganizational struggles but also to intraorganizational struggles in many fledgling programs and state or national networks. The turmoil affected victim and witness advocates, domestic violence shelters, rape crisis centers, and crisis intervention workers.

Despite the conflicts, the 1977-1981 period was the time when former victims started to become publicly active and vocal—a development that would become a central focus in the future work of the movement.

As indicated before, survivors of crime were probably a major force in starting and staffing the rape crisis centers and domestic violence shelters. But now other types of former victims were beginning to get involved, this time publicly identified as former victims.

Many of them turned to the field of victim services and often became the instigators of mutual-support and peer-counseling techniques. Parents of Murdered Children, a national self-help group formed by Robert and Charlotte Hullinger after the murder of their daughter Lisa, is an eminent example of victim activism in this period.

But perhaps the most prominent former victims of this period, like Mothers Against Drunk Driving founder Candy Lightner, turned to the political arena, demanding a host of public-policy reforms.

They sought to translate their private tragedies into a public testament that society was not doing its job. Their stories delineated the effect of indifference to victims not only of the criminal justice system, but also of the health, mental health, and social services systems—indeed, of everyone.

Victims talked of being ignored, isolated, and stigmatized by their families, friends, and neighbors. They related stories of seeking professional help and finding therapists whose training and experience served only to confound their sense of cataclysm by suggesting it was not as significant as their premorbid psychological status.

Many who were drawn to the new self-help groups found them to be more therapeutic than encounters with mental health professionals



simply because the group members understood what had happened during the criminal attack, could identify the suffering that followed the violation, and could define the elements of pain in the aftermath.

The influence of victim activists in the second phase of the movement's history was felt in three ways.

First, the testimonials of former victims, echoing the insights of their advocates and allies, led to the development of a taxonomy of injuries that victims suffer and a definition of appropriate responses. Now, at last, the aftermath of crime was being understood from the victim's viewpoint—not from the perspective of a society that wants to keep victims at a distance, or from the perspectives that had mixed these social prejudices with conventional professional wisdom, as found in the mental health, health, and criminal justice professions.

The second influence was a new infusion of purpose and fervor in the movement. Former victims brought an intense understanding of what victimization entails, and they also brought an intense motivation to make changes in the laws, social policy, and social programs. They insisted that seeing justice done was integral to restoring them to a functional life, and in making that case, they forced the worlds of mental health and criminal justice to discover they were not alien to one another. Both could now start to understand why victims were demanding the kind of respect from criminal justice that invites their participation at every stage, and why that respect-in-action might be called "therapeutic justice," which, on reflection, might just as accurately be called "felt justice" or simply "justice."

Third, many former victims had been abandoned by friends and family members as a result of their victimization. They found in their new self-help and advocacy groups and in the larger victims' movement a new sense of family, purpose, and trust. The movement was changed by the unique feelings of affection and determination they brought to it. In other settings, they might have attracted sympathy; in this one, they received well-earned respect.

A majority of the new victim activists were the surviving family members of homicide victims (including victims of homicidal recklessness at the hands of drunk drivers). Edith Sorgan, one of the early leaders of the new corps of victim activists, came to personify many others.

Grieving over the murder of their daughter Helen, she and her husband Phillip relocated from New York to New Mexico where, almost by chance, she telephoned a similarly grieving family she read about in the local paper. From there, an effective, statewide program of mutual



aid and political lobbying, the Crime Victims' Assistance Organization, was launched. With it, the one-time housewife became a force for change. She almost singlehandedly lobbied a victim compensation bill through New Mexico legislature (she was chair of the compensation commission at the time of her death in 1984), and through her work in NOVA, she became an encouraging role model for other victim activists across the country.

Like Edith Sorgan, other surviving relatives of homicide victims have had an ecumenical influence on the victims' movement, not simply because they have endured one of the most hideous losses that criminals can inflict and thus command a certain respect. Many of their leaders, in search of doing something to redeem a loved one's death, have reached out to victims of all kinds of crime. And many have developed an affinity with colleagues in the rape crisis and shelter movements, because they are grieving the loss of a rape victim, or a battered woman, or an abused child, who chanced not to survive those crimes of violence.

Collaborating with survivors of homicide victims gave the service providers new insights into what victims of many kinds of crime experience. To be sure, an unfair expropriation of someone else's belongings, or an undeserved assault on another person's pride, or the violation of someone else's body was still seen as unfair, undeserved, and violative. But the counselors now could see how these wrongs were also felt to be an existential confrontation with death.

The surviving families of murder victims have helped many service providers get closer to the unspeakable terror experienced by many victims. Learning to appreciate a victim's residual fears has been a cruel lesson, but somehow liberating, for it illuminates a kind of pain that transcends categories of victims and victimizations.

The third phase of the movement, from 1982 to 1986, has been marked by an extraordinary growth in the public's awareness of victim issues and the translation of the ideas of victim harm, treatment, and rights into tangible reforms.

In 1982, a Task Force on Victims of Crime was established by President Reagan to investigate the plight of victims in the United States. After six hearings in different parts of the country, during which the Task Force heard testimony from thousands of victims and service providers, it issued a final report that presented 68 recommendations on how the treatment of victims should be improved.

In the same year, the United States Congress finally seized on the victim issue. On October 12, 1982, the Victim and Witness Protection Act was signed into law. To victims of federal crime, it provided



improved protection from intimidation and harm, almost-mandatory restitution payments from convicted federal offenders, and a set of fair standards for treatment of victims in the federal criminal justice system—"fair-treatment standards" being that law's equivalent to the new "bills of victim rights" being enacted by many state legislatures.

The new status of the victim movement has been evident in the passage of not only 32 "bills of rights" (as of mid-1986), but hundreds of other pieces of state legislation relating to rights and services for victims; in the development of training and education programs for law enforcement officers, prosecutors, judges, mental health professionals, clergy, the media, and others in how to deal with victims of crime in a humane and understanding fashion; in an explosion of popular and scholarly literature on the topic; and, most important, in the rapid growth of victim assistance programs of all types.

That growth was accelerated by passage of the capstone legislative achievement of this era, the Victims of Crime Act of 1984 (VOCA). Fashioned by a bipartisan group of sponsors in the Congress, with strong support from the Reagan administration, VOCA called for the creation of a Crime Victims' Fund, derived from the collection of all federal criminal fines, forfeited bail bonds, and penalty assessments imposed on federal offenders. Funds so collected in one year are expended the next year as grants to support state victim compensation programs and local victim assistance programs. Most of the 40-odd states that had compensation programs liberalized their programs to make use of the federal grant that equaled 35% of their past year's compensation awards. Those states that needed to amend their laws to meet the two key conditions of the compensation grants: they would compensate any eligible victim, residents and nonresidents alike, and they would compensate for "mental health counseling." VOCA may also be used to support a modest victim assistance program for victims of federal crime.

Thus, as this is being written, one must conclude that the victims' movement is in a state of transition, with VOCA being a singular engine of change. Nevertheless, though it is too soon to tell for certain, there are indications that, in one fundamental way, the movement is not changing.

It appears to be retaining a strong allegiance to its grass-roots heritage—to the continued use of volunteers (a VOCA requirement, incidentally), and to an ethical, jurisprudential, and therapeutic value focused on helping victims regain control over their lives. Although observers in the mid-1970s often predicted that victim advocates would



be coopted by the systems around them, and that they would fall prey to "rescue fantasies" whereby they would become the victims' guardians and decision makers, there is evidence that the trends are in the opposite direction.

A central emphasis of that perspective is that the emotional consequence of victimization and its aftermath is probably the most important dimension of the victimization experience. Crisis intervention, supportive counseling, and the use of mutual-support groups have become the preferred, standard vehicles of response to the victims' emotional distress. The primary tool used in all programs is knowledge—knowledge about the normal stress reactions that victims face and the debilitations that commonly follow.

To victims, this knowledge is often received as a godsend, for learning what is normal for victims generally is to discover what is terribly abnormal for the individual who has never been victimized before. With the knowledge, they can calm down, stop fearing for their sanity, and put more energy into working through the crisis and grief they face.

The message repeatedly stresses that a loss of normal functioning, although usually not lasting, is too often brought on or made worse by forces beyond the victim's control. Victims insist that their remembered feelings of helplessness during the criminal attack are often reawakened in the criminal justice system where victims find that they may not even be passive bystanders, but rather an excluded nonentity, as "their" case proceeds through the justice process.

"Why didn't anyone consult me?" lamented a witness before the President's Task Force on Victims of Crime. "I was the one who was kidnapped, not the Commonwealth of Virginia." There is no just or humane reason for the kind of bureaucratic indifference that removes a victim from involvement in the just resolution of what may have been the most tragic event of his life.

Expanding on that complaint, victims often describe how a crime can render a person's ordered life chaotic, irrational, and fearful. Again, the felt loss of mastery over one's world is compounded when, for example, the victim is denied information about what is going to happen in the criminal justice system or why something already happened.

Still another variation on the same theme that is often conveyed by victims is that, for them, their sense of fairness has been shattered. They can accept the idea that the world has cruel people in it—like the criminal who harmed them—but they cannot understand, and will not accept, the unfairness and injustice they experienced from those



they turned to for support and encouragement—families, friends, the criminal justice system, therapists, and the like.

The larger lesson of what victims and their advocates are trying to teach is that their quest for procedural justice is aimed at correcting age-old human tendencies to shun or stigmatize the victim, tendencies that are all-too-naturally manifested in the rules, policies, and practices of society's formal system to deal with crime. To the victim activists, the merger of services and advocacy, of mental health and justice concerns, is an inevitable consequence of understanding and responding to the pain of victimization.

This review of the first 15 years of the victims' movement describes a diverse, sometimes quarrelsome, array of individuals who, as they grew in numbers, expanded their sights and their influence.

Although the movement has evolved into an increasingly "professional" network of services—with rigorous training programs being sought (if not always found) by practitioners—it appears also to be increasingly influenced by the consumers of those services, who have become far more outspoken participants in the movement's life and direction. One important by-product of that consumer involvement is to reduce the kind of factional divisiveness that is natural in so diverse a social organism.

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# 16

## *Support Services for Victims*

MARLENE A. YOUNG

### VICTIM RIGHTS AND SERVICES: THE CURRENT STATE OF THE ART

Victim services, in one form or another, now exist in all 50 states. There is a common understanding of what the full array of victim services should be in every community, but the scarcity of resources and the politics of resource allocation often dictate that such services be restricted to a certain type of crime victim or that certain types of services be implemented prior to other services.

The victims most frequently targeted first for programs of assistance are sexual-assault victims, domestic-violence victims, and children. Indeed, the Victims of Crime Act (VOCA) specifically names these groups as priority service recipients. Although there is universal recognition that these types of victims often have special and urgent problems and needs—and have long been subjected to a kind of malignant neglect by society—there is a growing acknowledgment by practitioners that other types of victims also have compelling needs, including relatives of homicide victims and persons who suffer catastrophic physical injury, to name two obvious examples.

With the infusion of VOCA funds, the time appears to be ripe for policy makers and public administrators, in alliance with victim advocates and service providers, to plan for a comprehensive system of services for all the potentially traumatized victims of their communities. Some years ago, in service to such planners, the National Organization



for Victim Assistance (NOVA) developed a generic model of victim services (see pp. 332-333).

The service components are designed to respond to the injuries that victims suffer and are clustered along a time continuum.

A simple analytical tool used in this and other NOVA publications is to classify the injuries victims may endure as financial, physical, and emotional, each as a direct result of the crime, though, of course, financial and physical injuries produce their own emotional harm as well. Any of the three may produce short- or long-term harm. To these is added the "second injury" caused by families and friends, social institutions, and the criminal justice system. The model stresses that the second injury may compound any of the direct injuries and may transform short-term losses into long-term stresses.

Services are divided into eight stages relating to the chronology of the victim's experience in the aftermath of the crime. More precisely, the model presents a pair of sometimes-parallel chronologies: the first three stages describe service clusters that are applicable to all victims, and the other five stages describe services that are important if the victim becomes involved in a criminal prosecution.

### *1. Emergency Response*

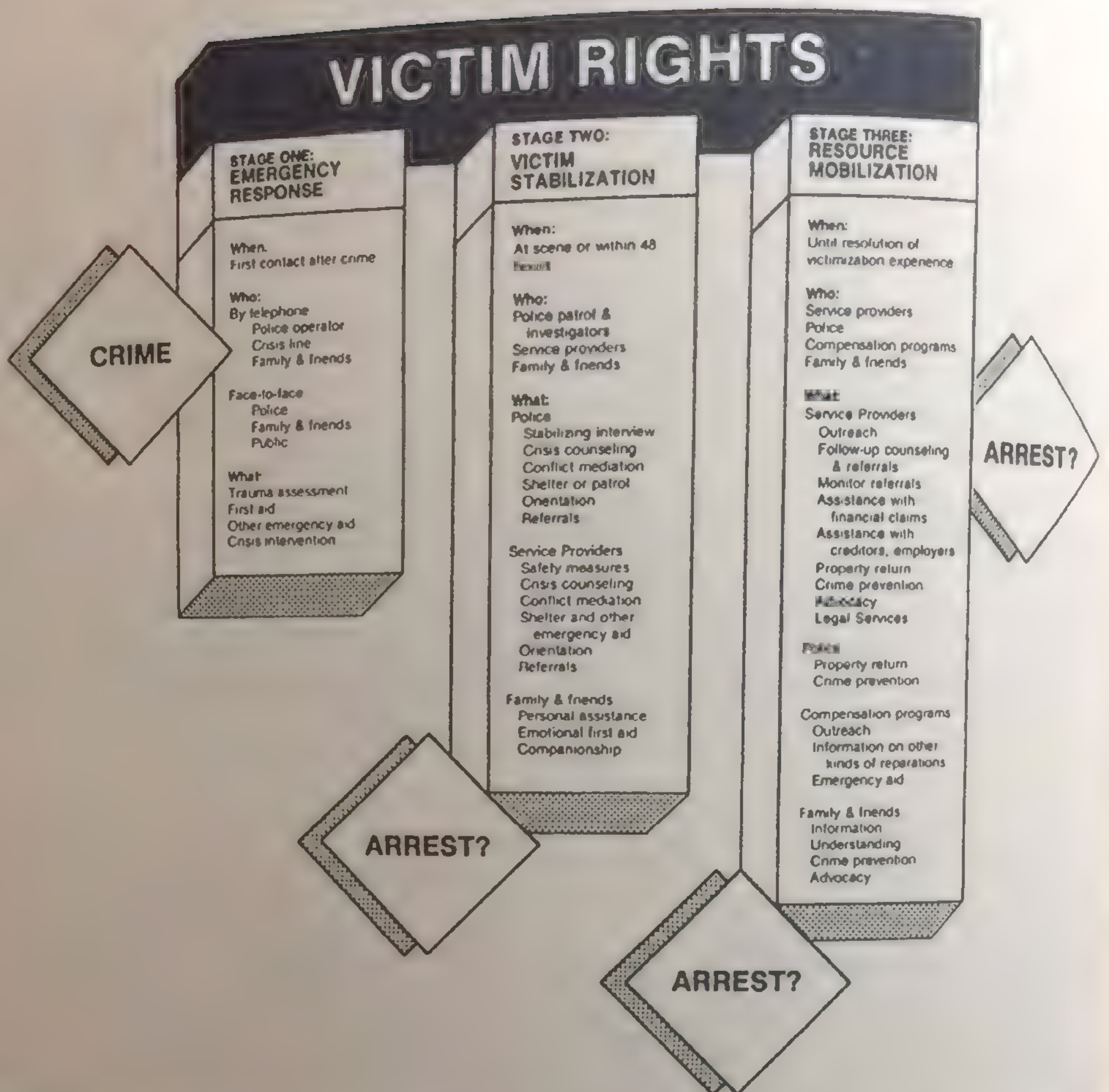
Emergency-response services should be available to victims as soon as they contact someone—the police, a crisis hotline, a neighbor, and so on—for help. The primary concern at this stage should be the physical safety of victims. The shock and disorientation that a criminal intrusion or attack can create in victims should not be ignored or minimized. The following incidents underscore the confusion victims often face and the importance of assessing the vulnerability of the victim to physical harm:

One victim reported that she called the police just after she had been knocked down in the course of having her purse grabbed. When the officer arrived, she said she was still very upset. She was determined to tell him exactly what happened, but didn't seem to be able to get the details out. After he had taken the report, the officer looked at her and said perhaps she should sit down because she looked pale. Only then did they both discover that she had a broken wrist.

A daughter of a burglary victim related that her mother had called the police to say she heard strange noises in her house. After getting the minimal information needed, the dispatcher said someone would



# The Victim



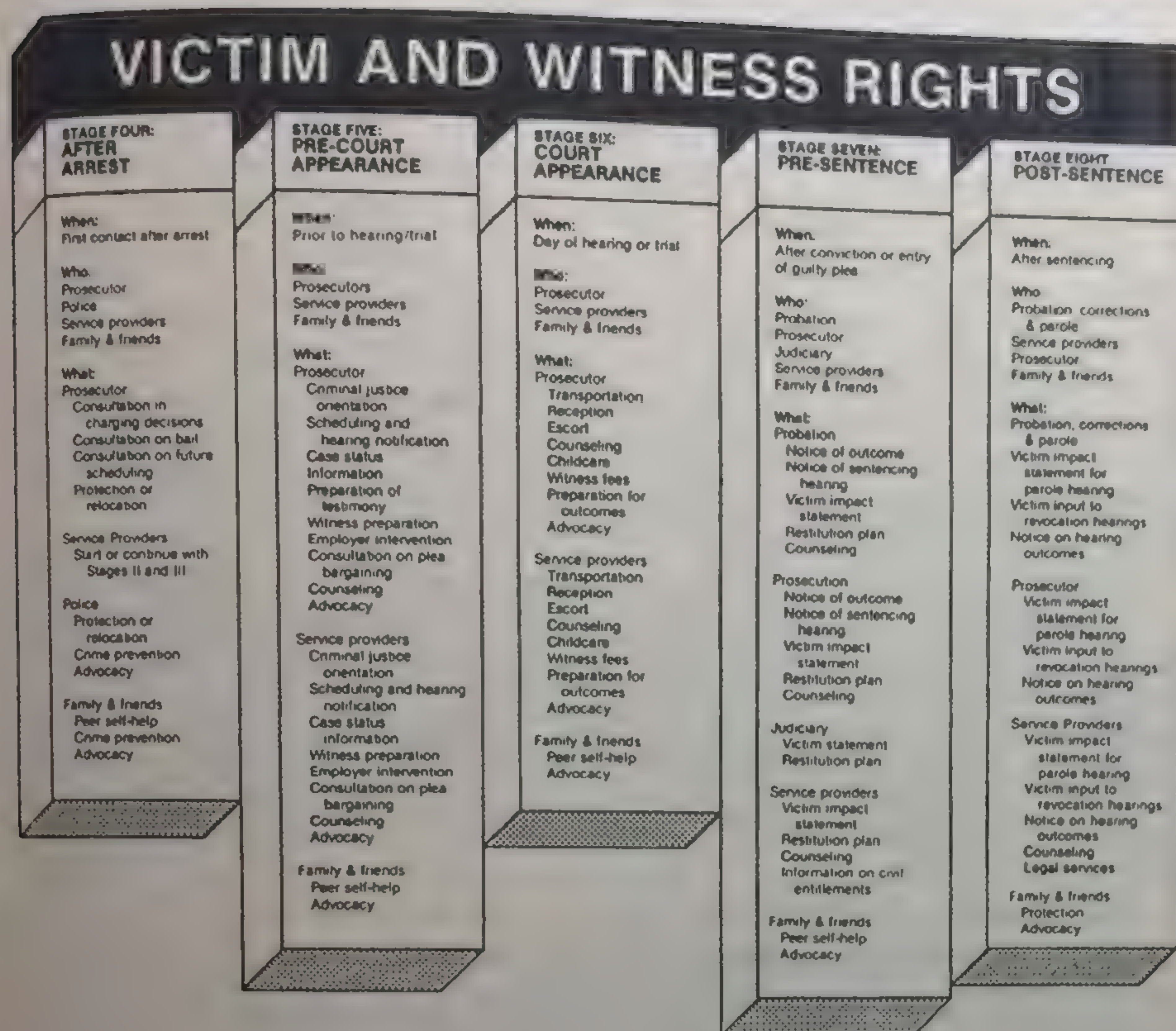
Source: National Organization for Victim Assistance, *The Victim Service System: A Guide to Action*, 1983.

be there as soon as possible and then concluded the conversation. A few minutes later, the burglar walked into the bedroom where she was sitting. Although he ran away, the woman whom the police met 20 minutes later was terrified.

At the emergency-response stage, the victim should be made to feel as safe and secure as possible. If the initial contact is through the police emergency dispatcher, who is the most commonly sought helper in these emergencies, it is important for the dispatcher to assess both the felt and actual physical danger. An increasing number of law enforcement agencies now make it a practice in cases of an apparent crime-



# Rights System



in-progress to keep someone on the line with the victim or witness, and a few even patch the call through the patrol officer who is responding to the scene.

Unfortunately, very few departments have as yet instituted for dispatchers the kind of training that is routinely given hotline counselors—even though the police emergency number is the most frequently used emergency hotline in every community.

If the helper is at the scene of the crime, he or she should assess any evidence of physical harm and provide necessary first aid after calling for medical assistance. If the helper is not at the scene or has



already taken care of physical needs, it is important to try to help victims calm down while they await further care.

This is the bridge between emergency services and the next stage, "victim stabilization." Dr. Martin Symonds (personal communication) has recommended three simple messages to be conveyed to the victim at this moment of high stress—messages that an increasing number of police officers and other "emergency responders" are using routinely. However styled, the three messages say: "I'm sorry it happened." "I'm glad you weren't killed." "It wasn't your fault." Each of these sentiments, dealing with the primordial fears of the recently traumatized, will be felt as highly reassuring. Though the dispatcher on the telephone may have no cause yet to provide these assurances, his or her assurance that the department is concerned and is trying to get help there as quickly as possible may keep the caller sufficiently calm until help arrives.

For the person who can with good reason give the trilogy of assurances—typically, the responding officer at the scene—it is important to view these gestures of comfort as psychological first aid, second in importance only to medical first aid. In practical terms, that means putting away the notepad for a time, looking for a place where the officer can sit down privately, and focus entirely on the victim or distressed witness.

This exercise (which often need not take more than one to three minutes) is good psychological first aid, but it has an important function for the officer: it is trying to bring back a sense of security to the victim or witness so that he or she can call up and retrieve the memories of the crime and, most important, of the criminal. All officers know how many inaccurate "lookouts" are broadcast on the basis of the first victim's or witness's reports; what few realize is that those descriptions are the best the person can recall in his or her traumatized state.

In some cases victims may call a crisis line six months or a year after a criminal attack—and that is the first time they have asked for assistance or told anyone about the crime. It is desirable at this time, as at others, to let victims tell their stories at their own pace, if circumstances permit it. But even if that first contact must necessarily be shorter than one would like, it is wise to use the "reassuring trilogy" to the degree it fits, for the victim may well be reexperiencing the fears of the crime.

In summary, the quality of the emergency response—based on its actual and perceived mastery over the medical and emotional crisis—will significantly influence the victim's later recovery and receptivity to receive help and to give help to the criminal justice authorities.



## Victim Stabilization

Services at the victim stabilization stage usually occur at the scene of the crime or within a day or two thereafter. Often two things are happening simultaneously at this time: while the law enforcement officer is trying to take a report, the victim is wrestling with feelings of being out of control. As already indicated, these efforts are often waged at cross-purposes. Thus, the reassuring trilogy is recommended as a method of stabilizing the victim. Note the example often cited by former police official James Ahrens (personal communication):

A couple who had just closed their liquor store for the night were confronted in the parking lot by two men, one with a gun. The husband momentarily resisted turning over the suitcase with the store's receipts and was shot. A half hour later, with many police officers at what was then a homicide scene, the wife was confronted with two men arrested a few blocks away. She positively identified them as *not* being the robbers—a statement she tearfully recanted a few minutes after they had been released. She tried to explain her certainty that they would kill her if she had identified them. (Fortunately, they were rearrested hours thereafter, along with the gun and the suitcase, and were convicted of the crime.)

Responding officers are pressed to establish quickly the kind of bond that words of assurance can evoke. They are often surprised at how quickly the victim does make that connection—as if the officer were a parent figure saying, "There, there" to a child with a skinned knee seeking comfort. The evident fact that all of us do turn to the primitive emotional stuff of our early years when our survival is felt to be at stake seems to explain why anyone—especially the uniformed officer—can be invested with parentlike attributes in times of high stress.

For the officer, moving from comforting (and stabilizing) words to the law enforcement business-at-hand is a delicate job. Ahrens and others recommend that the officer move from talk of "you" the victim, to "we" in law enforcement wanting to help, to "I" the officer needing some information from you. The process is one of trying to nurture the victim away from a state of understandable self-absorption.

What the responding patrol officer can do in a brief time to restore a sense of order and security to the victim, a detective or investigator can do at a slower pace, and a crisis counselor can do over as much time as is needed. That alone is an argument for training and entire



law enforcement agency in the techniques of crisis management and of giving them, and the victims, a backup team of crisis intervention specialists, preferably ones who are available to go to the scene of a crime and start working with the victim as soon as the responding officer has done his initial job.

But experience with putting that model into practice raises a caution: all of these interveners will at one time or another be given opportunities to take charge of the victim's life, in a sense—opportunities they should resist from the outset. If all interveners are trained to remember that the goal of these services is to reinvest in victims the control over their own lives that the criminal took away, they will all try to frame options for victims so that they can practice decision making again.

At the victim stabilization stage, the proffered decisions may be very simple, but they can set the tone. The questions that ask permission or guidance, and thus restore at least symbolic control to the victim, are typically these: Are you feeling up to talking with me? Do you like to be called Mr. Smith or Roger? Would you like a glass of water? Is there someone you would like to be with now? Would you like to call him or would you like me to make the call?

### *3. Resource Mobilization*

This stage of services largely focuses on meeting the victim's practical needs in the aftermath of a crime. Those needs can be lengthy and at times overwhelming. A sampling includes:

- Getting stolen property now in police custody returned;
- Replacing a stolen driver's license, social security card, credit cards;
- Replacing locks when the victim's keys were stolen; repairing damaged property;
- Filing insurance or victim compensation claims.

Helping the victim meet these social service needs, accompanied by case advocacy with agencies that may not be wholly responsive to the victim, may constitute the most time-consuming aspect of resource mobilization. But the well-designed service system also offers counseling services—a further extension of crisis counseling which becomes, in most cases where counseling continues, supportive counseling.

This is normally begun as a short-term program. It may involve discussions with a victim service provider or participation in self-help groups composed of people who have gone through a similar kind of



victimization. It may involve both, now that self-help groups have become an increasingly common adjunct to other types of counseling efforts.

Significantly, it is rare that traditional mental-health-service providers are involved in such short-term counseling plans. Victim counselors over the years have learned from victims that the "help" they had earlier received from psychologists, psychiatrists, and other therapists was often counterproductive. Hence, traditional mental-health professionals have been only occasionally sought out by victims or victim counselors. Usually this occurs if the case takes on dimensions that are beyond the counselor's skills. Such cases may involve substance abuse, revictimization emotional problems (including chronic mental illnesses), the effects of multiple victimizations, or simply the evidence that the victim has been seriously incapacitated.

For many years, and even now in many communities, making referrals to the traditional mental health professionals was distressing to victim counselors, so frequently did the reports back from victims reflect misunderstanding and mistreatment. But that is changing now in many communities. Typically first one therapist and then another start consulting with the victim counselors, find their perspective interesting and enlightening, and seek out from professional colleagues more insight on the psychological dimensions of victimization.

Those seeking to help the victim at this stage of service will often find that circumstances beyond their control or the victim's govern the course of the victim's recovery. Too often, these circumstances are hostile to the victim's interest and collectively add up to the second injury.

Families, friends, co-workers, and neighbors may attribute some kind of foolishness, bad judgment, character flaw, or worse to the victim. A sensational case will often provoke the news media to abuse the victim's privacy in their search of a good story. Coroners and morticians have added to the grief of many surviving family members of homicide victims. Even members of the clergy, who prior to a victimization may be a source of comfort and strength to an individual, may become a source of anguish afterward.

One woman, a mother of a murdered child, reported that her pastor requested her to come to the front of the church to pray with him in the aftermath of her child's slaying. She and other family members agreed and looked forward to the solace of congregational prayer. To their horror, the clergyman began the prayer by asking them to forgive their child's assailant.

Hence, counseling efforts may last longer than originally projected



should additional injuries be dealt to the victims. An arrest and prosecution may, of themselves, put the victim in an emotional holding pattern pending the resolution of the criminal charges, necessitating that little more than supportive counseling be offered during that waiting period.

The pattern of who provides services to victims in emotional distress will soon be changing. This is because, as of mid-1986, 44 states, the District of Columbia, and the Virgin Islands offer compensation to victims of crimes who suffer physical injury—and a few extend this offer of "insurance of last resort" to victims of certain traumatic crimes even if there was no physical injury—and virtually all these programs cover "mental-health counseling" as a compensable service.

Counseling is now explicitly covered in these programs as a condition of receiving a federal grant under the Victims of Crime Act of 1984. Programs that meet that condition (and the other major one, a pledge to offer compensation to residents and nonresidents alike) receive a grant equal to 35% of the program's awards the previous year. With that significant inducement, most programs are looking for opportunities to liberalize their benefits, and that will include encouraging a greater use of all forms of mental health counseling.

Two cautions might be raised about the growth of this field of service:

First, the maximum awards available from compensation programs are not high—\$25,000 is well above the current average. That puts pressure on the compensation administrators to respond to the occasional claims that exceed the ceiling in a way that best meets the needs of the victim and his past and prospective service providers. Those pressures have led most administrators to be worried about the "open-ended" and potentially expensive course of psychotherapy as it is normally practiced, a service system that could leave many victims bereft of compensation in the middle of their treatment (and could also, in the aggregate, put a financial strain on the compensation fund).

The second caution concerns the competency of the psychotherapists offering to provide compensation-aided treatment for victims. There is a growing consensus among those in the mental-health profession who have examined the question that the training and experience of most of their colleagues do not, of themselves, equip them to be effective counselors or therapists for trauma victims. But that recognition alone does not help victims or the compensation administrators locate therapists who have the requisite training and experience—and there have been only the vaguest of suggestions that there be established some



form of certification or other method of identifying therapists with the special qualifications.

#### *4. Postarrest*

For the vast majority of victims, the first three stages of service needs will be the only ones they face. The majority of victims never see their cases result in an arrest and prosecution.

But for those victims whose suspected assailant is arrested, their emotional problems are compounded, first by what doesn't happen to them. All too often, they will receive little information about the arrest, no consideration in bail proceedings, no notification about pretrial hearings, no consultation about a plea bargain (by which 9 of 10 convictions are arrived at), little information about trial proceedings, and no information or consideration at sentencing.

The exclamation point at the end of this list of bureaucratic insults is the rule in force in most states that bars a victim from even observing the trial proceedings—except from the witness stand.

Each such inaction by the criminal-justice system can exacerbate a victim's feelings of helplessness and chaos. Despite all the legal theories that say a prosecution is brought in the name of the amorphous "people," victims will always believe that it is "their" case that is being prosecuted (recall the victim's statement "I was the one who was kidnapped, not the state of Virginia"). When they are told they have no standing, no right to be involved, no right even to be informed, it makes no sense to them.

Focusing on how the postarrest manifestations of these problems are being resolved, prosecutor-based "victim/witness" programs in some jurisdictions now inform victims of an arrest, seek their opinion at bail hearings, inform them of the prosecutor's decisions as to what charges, if any, to file, and give the victim a minieducation about the procedures, language, and mores of the criminal-justice system.

Increasingly, these services are being mandated by a "victims' bill of rights" enacted by a state legislature. It is worth noting that active supporters of such legislation now commonly include mental health professionals who, like the editor of this volume, have testified effectively about the psychological harm that accompanies the procedural injustices that such bills of rights seek to end.

At the same time, it must be emphasized that such bills of rights are not self-executing, and even when they nurture the creation and expansion of victim/witness programs, their services do not always



cover all the outreach efforts and simple courtesies that NOVA's service model would like to see in place at this service stage and later ones.

And it must be particularly emphasized that providing every service and consideration suggested by the model does not eliminate the victim's ordeal that is an inevitable by-product of the criminal-justice process. The services merely eliminate some needless stressors and offer the chance that the ordeal will have been felt to be worthwhile.

That can be achieved when the victims' need to know, to have their views treated with respect (if not necessarily followed), is honored. The thirst for information about their case is, for most victims, virtually unquenchable. After observing and hearing victim reactions for years, most service providers concur that this need to know is a mental-health issue. If the information can be provided—even if it is negative—there is in most cases a positive effect on the victim's sense of self.

### *5. Precourt Appearance*

The need to know continues through all stages following an arrest. However, as more and more responsibilities are placed on victims and other witnesses, more and more assistance may be necessary to help them shoulder the tasks.

Victims in most cases are involved as prosecution witnesses, even if all they can testify to is, for example, what they found after discovering their home had been burglarized. As key witnesses, they often must appear at pretrial hearings or at the trial itself.

Such civic responsibilities can be overwhelming. Ordinary people are not familiar with the court, legal terminology, or the court process. They are aware that what they do in that system may affect the outcome of the trial. In most cases, they have a deep interest in seeing that justice is done, so they worry about how they will behave and how their actions will affect the outcome.

Though most start out eager to help the prosecutors, their eagerness is often abused to the point where many become poor witnesses or simply do not show up for a hearing or trial. Common abuses are postponements of cases without notification to victims; lack of information about what is expected of the victim; harassment in examination and cross-examination in pretrial interviews and preliminary hearings as well as in trials; being fired or docked in pay because of court participation; and the simple expenses of parking, child care, transportation, and the like in order to participate in court proceedings.

If victims withdraw from the case because of such pressures, they



may become depressed and upset because they did not help as much as possible. If they remain in the system, they may find they are living in constant anxiety because of the uncertainties in the court system.

In jurisdictions with victim services, such problems are often mitigated by victim service providers who not only provide information on the case, and assist in scheduling problems, but also serve as counselors to victims as they confront each additional trauma. Indeed, the trend in many prosecutors' offices is to use victim/witness staff not only to cut the bureaucratic red tape for victims, but also to communicate the victims' interests and concerns to the attorneys—a process that puts the victim/witness staff increasingly in the roles of counselor/advocate, on the one hand, and of paralegal aides to the prosecutors, on the other.

The paralegal aspects of these evolving job descriptions are interesting. As attorneys get used to the idea of in-house staff actually speaking up for the victims, they often discover that the counselor/advocates have interesting and useful insights about the prosecutors' witnesses—which translates into shaping the strategy they pursue in seeking guilty pleas or preparing for trial. Though it occasionally happens that the victim/witness staff will develop "hard" evidence of use to the attorneys, it is their less direct, "humanizing" influence that is probably having the greatest effect on the quality of prosecution services—and on the gratifications of being a prosecutor.

These qualitative effects of new victim rights and services converge most tellingly on plea bargaining, which is the most common, consequential event that takes place at this stage. The increasingly common rule that prosecutors must consult with victims prior to entering plea negotiations has produced two notable changes and one surprising nonchange.

First, prosecutors who talk to the victims before discussing a possible plea with defense counsel know what their case is "worth" (to use their vernacular) far better than when they relied solely on the information written on a sketchy police report. This strengthens their hand in fashioning a just resolution through the somewhat-informal way most convictions are obtained. Note that it is the better practice for the prosecutor, not the victim/witness staff member, to make that consultation call to the victim.

Second, the evidence is that victims are extraordinarily gratified to get that call. In the vast majority of cases, the victim is persuaded of the wisdom of the prosecutor's proposed "bargaining position" after his or her reasoning is explained. Even if the victim thinks the proposed



solution is not commensurate with the harm the offender did, the idea of avoiding the stress of a trial and the anxieties of having a jury's conviction endlessly appealed makes the certainty of a plea look appealing. Beyond these practical issues is the message of the call itself—one that says the victim's dignity and interest in the case mandate this important act of consultation.

Third, the nonchange is any discernible effects of the consultation system on the severity of pleas and sentences. One can speculate that this reveals the persuasiveness of prosecutors in their dealings with victims. A larger factor may be that victims are not as vindictive as others assume. Anecdotal reports tell us that many victims—perhaps a minority of the total—would be satisfied with a sentence that would be less harsh than is the norm in a given community. Whatever the reason, there is increasing evidence that it is the process of justice, not the product, that most concerns victims.

#### *6. Court Appearance*

The problems that victims face prior to a court appearance are similar to those they encounter when their day in court arrives. However, in one critical aspect those problems grow larger the closer the victim gets to taking the witness stand, for in the anticipation as well as the event itself, victims have to relive the facts of the criminal incident itself. The very recounting of the trauma, especially in that setting, often triggers a reexperiencing of the crisis and all its manifestations.

Many victims find it difficult to confront their assailant. The person's face and presence is a terrorizing reminder of what happened. If the accused by word or deed threatened the victim during an assault, the victim may be terrified at the prospect of testifying against someone who may try to retaliate at the next opportunity—which may come soon if the defendant is acquitted or is given a light sentence.

Fears about what will take place on the witness stand are well founded. Often, victims and their families must sit quietly by and listen while their credibility is impugned. They may have to endure a cross-examination designed to put their honesty into doubt or to belittle the seriousness of the crime. Particularly in sexual-assault cases, the victim's character may be at issue and her prior sexual conduct put under scrutiny. Even in jurisdictions that have a rape shield law, victims are often unprotected from these intrusions.

Similarly, in homicide trials, the family members of the victim may be exposed to an attempted justification of the homicidal assault by



painting their loved one as a hateful person (and painting the accused as a sympathetic figure). Both portraits are often painfully surreal to the family members.

As a result, victim service providers feel that in addition to practical assistance such as transportation, child care, and the like during a court appearance, it is imperative in some cases to prepare the victim well for the upcoming experience and to provide him with special support on the day of the court appearance.

In preparation, many victim/witness programs make sure that the victim observes one or more trials so that they gain some understanding of the people, the process, and the less-than-sensible rules that govern court proceedings. Victims are often brought to the actual courtroom (when not in use) where their case will be heard, to sit in the witness chair, "test their voice," and get more comfortable with their surroundings. Prosecutors will often review their expected questions with the victim, even role-playing a cross-examination.

Victim/witness staff are generally discouraged from doing more than review the basic principles of being an effective witness—"dress appropriately," "try not to lose your temper," "tell the truth," and so on—so that, for example, the witness's testimony will have the kind of spontaneity that can be lost if he or she is "overrehearsed."

On the day of the hearing or trial, service programs often provide the victim with a court escort who is trained to help victims understand the process and endure it. Most escorts are also victim counselors who can help victims debrief after each appearance. In especially traumatic cases, the normal preference is to have the victim's regular counselor accompany the victim.

## *7. Presentence*

Inexperienced observers often think that after the verdict, the case is over. However, for victims the period following the verdict or guilty plea may be even more emotionally draining. Victims who have watched the accused be found not guilty are often embittered about the system and may need support as they attempt to find some rational explanation for the result. Even victims who themselves harbored doubts about the guilt of the accused may feel lost after an acquittal.

When the accused is found or pleads guilty, the victim must prepare for the next stage in the criminal-justice process, the sentencing. A number of things should be done during this phase.

First, victims should be assisted in working with the prosecutor to



make sure that a request for restitution is included in the proposed sentence, and that such restitution is reflective of the damage done. That means taking time to document past and future costs justly attributable to the person who caused the damage, loss, or costs.

Second, victims may need help in preparing a victim impact statement to be presented in writing, or in person, or both ways. Such a statement is now allowed in 34 states and is designed to give the judge an objective description of the medical, financial, and emotional impact of the crime on the victim.

In some states, there is an explicit or implicit right for the victim to also give an opinion about what is an appropriate sentence, usually through an oral statement at the sentencing hearing.

Although the majority of victims cooperate in preparing an impact statement—at least when others are given the responsibility of actual writing of the statement—only a minority of victims who are allowed to speak at a sentencing hearing do so. But nonparticipation is not the same as indifference. Most nonparticipants believe that having had the option was important to them. And most of the victims who do participate emphasize that the sentencing hearing was, both figuratively and actually, their day in court. Some speak of that talk almost as a rite of passage on their road to recovery.

Third, the preparation of victims for sentencing includes predicting for them the range of sentences possible and making a realistic assessment of a likely sentence. That prediction should include not only the sentence itself, but what it means in terms of the length of time in prison, when that seems the likely sentence. Victims are often stunned to learn that a 10-year prison sentence may only mean three years when the parole practices and "good-time" allowances are factored in.

Once again, a trained staff member or volunteer to accompany the victim to the hearing is advised. No matter what sentence is imposed, victims and their families will feel emotionally exhausted by the process.

#### *8. Postsentence*

After the sentence, mental health services may become even more important. Many victims essentially put themselves and their needs aside while they pursue justice through prosecution and conviction. Their sense of mission, of seeking the restoration of fairness in their lives, overwhelms other aspects of their emotional life.

Hence, it is common for victims to return from a sentencing hearing, even when the sentence is exactly what the victims wanted, feeling



depressed and isolated from the world. They suddenly feel alone and detached from other things. The flurry and frustration of the trial are over. There is nothing more to be done. Their purpose either has been accomplished or has been flouted. And the activity that kept their grief from surfacing has ceased.

The availability of a counselor at this stage is crucial to many victims. They are often unaware of why they are feeling so badly and do not understand their own distress. For those who have convinced themselves that a "just" sentence will be a catharsis, they are disillusioned when the euphoria vanishes soon after the desired sentence is imposed. Whatever the nature of the deflation, victims need to be reassured that it is normal and a natural reaction at this time.

If the victimization suffered was particularly heinous, and the sentence was severe, everyone should be on notice that the victim may not be at the end of the process but only at one early stage of a legal struggle that may endure for years, during which the victim may again find himself consumed by the case.

Murder convictions—particularly those producing life sentences or the death penalty—will almost always be appealed. Survivors of murder victims and other victims of viciousness may face numerous appeals and retrials and undergo the trauma of recounting their horror and the grief over and over again. For these victims, ongoing support and understanding are vital. For this reason, experienced victim service providers who work with survivors of homicide victims stay in touch and offer supportive counseling for years.

In addition to the counseling needs of victims in the postsentence phase, there are still information and notification needs. The victim may want to keep informed as to the offender's prison, probation, or parole status. Some states are now developing programs that keep victims informed about these concerns, and a growing number of states give victims an opportunity to express their opinions about paroling the offender.

Victims may wish to pursue legal recourse through civil courts after the criminal case has concluded. Damage suits against offenders are not uncommon, and suits against third parties who failed in meeting a duty to prevent the victimization are increasingly brought and won. Referrals to appropriate legal resources may be useful. If such actions are taken, victims may need continued support through that process in much the same way as they received it during the criminal case.

This concludes an overview of the complex nature of victim assistance as it is coming to be practiced in a number of jurisdictions. What has



become apparent to many service providers is the intricate relationship between the social-service, legal, and mental-health issues that arise in the aftermath of a crime. To both service providers and victims alike, one of the chief failings of traditional mental-health professionals rests in their ignorance of the impact of trauma in general, but a criminally induced trauma in particular, in the lives of the victim.

The kinds of personal services reviewed here are only one aspect of the need to be more responsive to victims. These services are mostly delivered one-on-one, and so depend on the availability, commitment, and skill of individual helpers.

Most victims who become active in the victims' movement look beyond the availability of such helpers on a case-by-case basis. To them, the larger need is to establish in law the procedural considerations and access to services that are now given sporadically as a matter of sufferance, not right. Former victims argue that despite substantial improvements in the treatment of victims in many jurisdictions, the majority of communities still do not have services and the majority of victims still face isolation, blame, and injustices through the stigmatizing effects of crime.

To victim advocates, the systemic answer to these grievances has been the adoption and enforcement of a code of victim rights. Some of those rights were highlighted in the overview of NOVA's eight-stage service model to illustrate the interplay of responsive services and responsive rules and procedures. What follows here is a summary of the full range of victim rights that NOVA first propounded in 1980, when no state had yet legislated a "bill of rights" for victims. Since that time, 33 states have enacted such legislation, the federal government has followed suit, and the United Nations has even issued a Declaration of Principles on the subject.

None of the statutes on the books is as sweeping as the code articulated by NOVA at the beginning of the decade. But as time goes by, the states are getting ever closer to translating into law all the broad statements of rights that have guided NOVA's advocacy efforts. These are:

1. The right to protection from intimidation, harassment, and retaliation by the suspect or his associates;
2. The right to timely information and notification about what is happening in the criminal justice process from the initial investigation through all the postsentencing activities;
3. The right to counsel concerning emotional needs, to legal coun-



sel when the victim's integrity is under legal attack, and to consultation over such critical decisions as a plea bargain or a sentence;

4. The right to reparation through compensation and restitution; the right to have stolen property that has been recovered quickly returned; the right to services from the criminal-justice system at no cost to the victim or witness; and the right to employment protections when a witness must take leave to participate in the criminal-justice process;
5. The right to due process in the courts, such rights being the counterparts to those constitutionally accorded the accused; and
6. The right to dignity and compassion.

The last of these rights is, of course, a summation of all the others, with "dignity" being a call to end the bureaucratic indifference and worse that greet victims, and "compassion" being the call for social and mental-health services for them.

#### FUTURE TRENDS IN VICTIM SERVICES

In the past 15 years, there has been a dramatic change in the understanding of what it is to be a crime victim and how some of the needless pains inflicted on victims can be ameliorated or eliminated altogether. The reforms that have been adopted in furtherance of this goal have been extraordinary, and although practice still lags behind principle, a new social-service industry, engaging tens of thousands of paid and volunteer counselors and advocates, seems determined to make good on society's new commitments to victims.

But to this observer, the second 15 years of the victims' movement should produce an even larger body of change than did the first 15 years. If that prediction proves accurate, we will recall the mid-1980s as a time when the victims' movement had only begun its reform efforts.

The knowledge we have gained from former victims and the services we have instituted in response to that information are valuable. But they also suggest to many of us that there is much more to learn and to do. Work is needed in research, in service delivery, and in public-policy development.

One group of victims makes a special case for greater sophistication in our understanding and response. Violence committed within the



family structure produces in its victims many of the same service needs as are found in victims of stranger violence. But the differences are important, too. The sense of betrayal of the human duty to protect and nurture one's family members has a profound impact on the nature of the harm, as does the pattern of socially isolating the victim that so frequently accompanies chronic intrafamily abuse.

One might cite other special cases—the victims of political repression, of hostage taking, of impersonal “white-collar” crimes, as examples—to remind us how great is our need for particularized research in this field and how generalized is our present research base. That is changing, with research in all aspects of family violence showing the way, but the pace of change has to increase if we are to have in place a truly effective service system by the turn of the next century.

Most of what is known has been gleaned from clinical experience and testimony from victims themselves. That testimony is an excellent foundation for more complicated, empirical research. For example, the clinical reports from the Dimondale stress reduction program, with some of the more novel insights evidently coming from the participants themselves, propound a full research agenda, and the same can be said of scores of other thoughtfully administered service programs.

In thinking about a common agenda for the researchers, clinicians, counselors, advocates, and activist victims in the years to come, a number of observations can be made.

First, there seems to be a general consensus on the immediate crisis reaction of victims to crime, but the long-term effects of serious victimization have yet to receive an adequate response. This is obviously a problem that should be addressed through collaboration between victim service providers and mental-health professionals.

Second, anecdotal evidence suggests that the stresses victims encounter in the aftermath of crime not only have deleterious psychosocial effects, but also can lead to serious physical disorders. There is a well-recognized need for longitudinal research to document these effects and to uncover what medical interventions may prevent or reduce the severity of these physical disorders.

Third, case studies indicate that although most victims of serious crime suffer emotional turmoil, some victims have more difficulty coping with the chaos than others. Some victims may take longer to restructure their lives, while others seem never to resume a functional life. There is a need for research on identifying victims in the high-risk category and in devising early and intensive interventions to lower their risk of long-term debilitation.



The fourth observation flows from the third: we have little to guide us among the different types of interventions we have devised, and the idea of differential diagnosis and treatment found in one service center is rare. High on the research agenda of "what works and why" should be a study of self-help groups, their dynamics, successes, and failures. These are, after all, the preferred tool of support and recovery of many victims and an increasing number of service providers.

Fifth, there is limited information or analysis on the effects of multiple victimizations. In considering this issue, there should be an effort to examine not only the impact of multiple crime victimizations, but the effect of several different kinds of victimizations (disaster, accidental, racism, and the like) on a single victim.

Sixth, the structure of service delivery in the future may also see vast change. Most important is the need to get services to special population groups that are infrequently or ineptly reached by victim assistance programs. These population groups include racial minorities, gays and lesbians, the elderly, the differently abled, refugees, undocumented workers, and the chronically mentally ill.

Seventh, services need to reach all types of victims. Although there are rape crisis services in most communities and domestic-violence programs in many areas, there are still almost no services to help burglary victims, survivors of homicide, victims of catastrophic physical injury, arson victims, vandalism victims, and others. It is ironic that, statistically speaking, the most common victims of the most traumatic of crimes—that is, the families of young, black males who have been murdered—are effectively excommunicated from victim services because of their demographics and the nature of the crime that has affected them.

Eighth—to harp on a recurring theme—it is critical that the established mental health professions become more informed and involved in victim services. Even though the use of self-help groups and lay counseling will undoubtedly remain the core service, they and the victims they serve will have increasing need of clinical and empirical researchers, and particularly of psychotherapists, if the movement is to fulfill its mission in the coming decades.

To expand on this point, one should recognize that the lay victims' movement holds the mental-health professions in an ambivalent esteem. Few of their members were there at the founding of the movement, and many of their practitioners, through ignorance, have not been helpful to their victimized patients. But overshadowing these old problems are the contributions of pioneers in the mental health professions



whose research and analyses have guided lay counselors in improving their skills.

The formulation of the post-traumatic stress disorder, with its grounding on work with Vietnam war veterans, disaster victims, and victims of terrorism, has given much-needed coherence to the work of the movement. But the way that singular contribution got to the service providers is instructive—it leaked, slowly, into the field years after its publication.

To avoid repeating that history, we should work to recognize the emergence of a new field of study and work that is genuinely multi- and interdisciplinary, one which recognizes that "lay" experience and client insight, alongside professional education and training, all have validity in the formation of knowledge and services.

Ninth and finally, the future of the victims' movement will be marked by a trend toward ensuring that victims have status and stature in the criminal justice system. Victims already recognize that legislated bills of rights are nothing more than rhetoric unless legal remedies are available to enforce them. The next decades will in all probability see a number of legal and legislative battles to establish those remedies. Joining in those battles will be psychiatrists, psychologists, psychiatric nurses, and social workers, all of them seeking to explain that "justice" and "mental health" have the same overlapping connection as do mind and body.

The most important characteristic of the victims' movement of the future is that former victims will have claimed their right to be part of what takes place in the name of victim-oriented research, services, and public policy. More than ever, they will look to the rest of us as helpers, not leaders, in their quest for regained control over their lives.

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## Editorial Postscript

This book is the eleventh in the Psychosocial Stress Series. Readers are urged to consider other books in the Series for both background and extension of this outstanding volume.

The first volume in the Series, *Stress Disorders Among Vietnam Veterans*, published in 1978 and edited by Charles R. Figley, focused on the immediate and long-term effects of war. It alerted the nation to the difficulties of coping with one's war experiences long after the war was over. It provided a state-of-the-art source book for scholars and practitioners working in the area of war-related stress reactions and disorders. With the publication of this book and other resources, mental health professionals and policymakers began to recognize the complexity of the postwar readjustment of Vietnam veterans. Soon a national outreach program emerged within the Veterans Administration with storefront Vet Centers in every major city in the country and inpatient treatment programs in many VA Medical Centers across the country to focus on these problems. As a result, thousands of professionals have since become aware of the special circumstances of war veterans.

The next two volumes in the Series, *Stress and the Family, Volume I: Coping with Normative Transitions* and *Stress and the Family, Volume II: Coping with Catastrophe*, edited by Charles R. Figley and Hamilton I. McCubbin, provide a comprehensive summary of the available information about how families cope with psychosocial stress. The former volume attends to the typical and predictable stressors of family life, while the latter volume focuses on how families cope with extraordinary and unpredictable stressors. Each chapter follows the same outline, which first introduces the stressor, then identifies the functional and dysfunctional ways families and family members cope.

*Trauma and Its Wake, Volume I: The Study and Treatment of Post-Traumatic Stress Disorder*, edited by Charles R. Figley, is the fourth book in the Series. It is the first attempt to generalize research and clinical findings among a wide variety of traumatic or catastrophic events toward



a generalized view of traumatic and post-traumatic stress reactions. Chapters focus on the immediate and long-term psychosocial consequences of exposure to one of many types of catastrophic events: war, rape, natural disasters, incest. Other chapters focus on effective methods of treating or preventing stress reactions or disorders. It is the first in a series of books that will review the latest innovations in theory, research, and treatment of this disorder, caused by wide variety of stressful life events.

The fifth volume in the Series, *Post-Traumatic Stress Disorder and the War Veteran Patient*, edited by William E. Kelly, focuses on war veterans in general, and Vietnam war veterans in particular. Building upon the most important contributions of the past, this volume provides a specific blueprint for conceptualizing and treating war-related post-traumatic stress disorders.

Similar to this eleventh volume, the sixth volume, *The Crime Victim's Book*, written by Morton Bard and Dawn Sangrey, deals with yet another context in which individuals struggle to manage their violent life experiences. This book is written as a primer for those interested in working with victims of crime, particularly violent crime, although the authors hoped that victims themselves would read it. It provides summaries of two important recent task force reports: one produced by the President's Task Force on Victims of Crime and the other by the American Psychological Association's Task Force on the Victims of Crime and Violence, chaired by the book's senior author.

*Stress and Coping in Time of War*, edited by Norman Milgram, is the seventh volume, but the first in the Series to focus on an international issue: the special psychosocial stress of war upon not only those who fight, but the nations, communities, and social systems directly affected as well. Although the volume focuses on the special circumstances faced by one country, Israel, its content has far-reaching implications for any nation that must commit its resources toward an all-out national defense. This book focuses on the *context* of war and its multilevel impact. It is the first to focus on war-related stress and coping at the levels of the individual, the group, and the nation-state.

The eighth book in the Series is the second in a series within this Series. *Trauma and Its Wake, Volume II: Traumatic Stress Theory, Research, and Intervention*, edited by Charles R. Figley, is the state of the art in theory, research, and treatment associated with the Post-Traumatic Stress Disorder (PTSD). And PTSD is the latest and most significant conceptualization of the negative consequences of extraordinary, catastrophic stressors. As with the first volume of *Trauma and Its Wake, Volume II*



includes the thoughtful work of scholars—both researchers and clinicians—from all of the major mental health disciplines. They focus on the explication and application of knowledge about the psychosocial impact of traumatic experiences: how the *memories* of extraordinarily stressful life experiences invade the everyday life of those who survived them. The chapter by Jacob D. Lindy, "An Outline for the Psychoanalytic Psychotherapy of Post-Traumatic Stress Disorder," served as the initial thesis for and eventuated in his recently published book, which is part of this Series.

The ninth book in the Series, *Stress and Addiction*, coedited by Edward Gottheil, Keith A. Druley, Steven Pashko, and Stephen P. Weinstein, is the first to link, in a systematic and scholarly way, factors of psychosocial stress and addiction. In all, 27 scholars collaborated to contribute 21 chapters to this volume. Although the volume is research-based, it provides important directions for clinicians working in either the stress or addictions area, and particularly for scholars who are focusing their efforts on the interface between the two areas.

*Vietnam: A Casebook*, the tenth book in the Series, elaborates and exemplifies the Lindy approach to psychotherapy with Vietnam war veterans. In collaboration with his friends and colleagues, Bonnie L. Green, Mary C. Grace, John A. MacLeod, and Louis Spitz, and with contributions from six others, Jacob Lindy provides a sensitive guide to clinicians who care for Vietnam veterans and those whom they care for.

This eleventh book in the Series fits well along side these books, which focus on the immediate and long-term impact of a wide variety of psychosocial stressors. Congratulations to Dr. Ochberg and his contributors.

Charles R. Figley, Ph.D.  
Series Editor







# Acknowledgments

This volume took shape several years ago during discussions with Martin Symonds, Alexandra Symonds, and Susan Salasin. Each has made significant contributions to the national movement for victims' rights, particularly the right to competent mental health services. Marty Symonds developed the concept of *second injury*, the wound inflicted by insensitive interveners after the assailant has fled. Allie Symonds clarified the burdens borne by women in today's culture and diffused the noxious stereotype that blames women for their subjugation. Sue Salasin led the struggle within the federal government for adequate understanding of the emotional cost of victimization. To these three colleagues I express appreciation and gratitude.

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